Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year  $A^{M}$ **Physician** 1:40 2009 April 18 Tucker Everett Ear1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) 01-07-1917 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☑ M 2 ☐ F Yrs. Maryland 92 Director <u>213-36-1372</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, If a Modical Exterior errors once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🙀 No **Funeral Director** Lothian Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20711 811 Marlboro Road Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) farmer agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Everett Tucker ၀ William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 811 Marlboro Road, Lothian, MD Mary E. Tucker, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Calvary Cemetery 04-22-2009 Lothian, MD 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1den /Medical Due to (or as a consequence of): Examiner plication Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed tural and burial-trar Due to (or as a consequence of): Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. detached 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 ☐Yes 2 ⊞No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year)

D4-15:2009

28b. Time of AM linjury at Work?

LACTTIME

1 □ Yes 28d. Describe how injury occurred ie Hospital or Attending Pin 24 hours after death. 27. Manner of Death 1 Natural 5 Pending Patient 1 ☐ Yes 2 🗹 No investigation 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide EN MARI bono home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the l within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 D0065230

Registrar
DHMH 17 Rev 1/2001

10

State

den

Medical Pkny Anno

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Farroth somals.

31. Date filed (Month, Day, Year)

AAMC 2001

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03431 State of Maryland / Department of Health and Mental Hygiene Dorothy Liola Thomas 2009 14502 Certificate of Death 1- For State Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ April 28, 2009 2119 hrs Thomas Viola **I Examiner** Dorothy 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Upper Marlboro 10200 Old Indian Head Road Date of Birth (MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** country shington DC Hours Months Days 01/27/1934 Director 578-44-0180 1 M 2 X F 75 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Yes 2 X No Upper Marlboro s 23a or 28a-f show e notified at once. Prince George's MD Director 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20772 10200 Old Indian Head Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes white Specify: Divorced If Yes, Give Year Yes 2 X No specify! 4 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) than, marked other than ' elementary school timore, MD 21215-0036 t. Pages I and 2 should be filed within 77 trment of Health and Mental Hygiene. teachers' aide 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stine Dorothy Fillmann Be George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11401 Cheltenham Road, Upper Marlboro, MD 20772 item 27 is Steven Thomas, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Cremation 3 Removal from State X Burial 2 05/04/2009 Waldorf, MD Trinity Mem. Gardens Important: injury or oth Other Specify Donation 5 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Lig 8325 Mt. Harmony Lane, Owings, MD Mas the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line. **Medical** Smoke inhalation and thermal injuries Immediate Cause (Final disease \_x́aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit AMENDED 23a,2/,28a-f,perME, g891 5/12/09 TT Physician/Medical physician the burial -X UNPENDED or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy Year Month Day 23b. Was decedent pregnant in the Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 ✔ Unknown ğ Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No 1 🗸 Yes ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 27. Manner of Death Certification: victim of house fire 1 Yes 2X No Natural Pending Fd 9:19 pm Fd 4/28/09 28f. Location (Street and Number of Rural Route Number, City or Town, State) 10200 01d indian Head 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide house Rd. Upper Marlboro, MD determined Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ORIGINAL

29c. License number

Division of Vital 24 hours after death.

e Funeral Director: A letely filled in by the fu To the Hospital

O.C.M.E. 44hellin1 30. Name and ddress of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) Registra

29b. Signature and title of certifier

April 29, 2009

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland		rtment of H	ealth and M Death		ene2 () (	9	14503
			1. Decedent's Name (First, Middle, L						2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		Preston Jame	es Taylor					April 1			6:50 a M
	Examin		4a. Fecility Name (If not institution, gi	ive street and number	er)		4b. City, Town, or	Location of Death		4c. County	of Death	
			3501 Snow Hill	Road			Gird1	etr <b>e</b> e		Wor	ceste	
	Funeral		Social Security Number     6.	Sex 7.	Age (In yrs. la	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl	lece (State or Foreign try)
п	Director		215-38-1528	10 M 20 F	68	Yrs.			Apr. 4, 1	1941		yland
	and w		Usuat Residence of Decedent  10a, State 10b, County		10c. City.	Town or Lo	cation				10	0d. Inside City Limits
	faryli sho	ō	MD Word	cester								1 Yes 2 No
	the A	Director	10e. Street and Number	rester	GIL	dletr	10f. Zip Code		10	g. Citizen of W	hat Coun	trv?
	with a or		3501 Snow Hill	Road			2182	9		U.S.		,.
	be filed within 72 hours after death with the Maryland lal Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Examinar must be multiplial at	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S	i. 13. V	Vas Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-			an Indian,
•	fter d	표	1 Never Married 2 Married	Armed Force		l I	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Blac	k, White, o	etc.
21215-0036	hours after tural', or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	s: 1960	1	☐ Yes 2⊠ No	Specify:		Specify	wh	ite
Ş	2 ho	Completed	15. Decedent's I	Education			ent's Usual Occupa	ation during most of work		6b. Kind of Bu	siness/Inc	dustry
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	od wil	000	10				Truck Dr	iver		Tran	sport	tation
	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Las	5t)				18. Mother's Name	e (First, Middle, M	aiden Sumam	9)	
Maryland		2	Thomas Lee Tay	lor				Louise 1	Eva Ward			
al	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	and Number or Run	al Route Number,	City or Town,	State, Zip	Code)
	is 1 and of Health item 27 other tr		Ruth R. Taylor	(Wife)	1		Snow Hil		Girdletr			
50	of H of H If ite		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from Sta		ice of Dispo: metery, cren	sition (Name of natory or other plac		Date 2	0c. Location -	City or To	wn, State
Ĕ	Pages ment of ant: If it ury or o		* 4 □Donation 5 □ Other (Spec			nghil	l Cemeter	y 04-21-	<b>-</b> 2009 G	Girdlet	ree,	Maryland
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		21. Signature of Funeral Service Lice	ensee '		22 S1	Name and Address nort Fune 3 East Gr	ss of Facility ral Home ove Stree	et Delm	nar, DE	199	940
Į.			23a. Pert1. Enter the disease, or co	mplic tions that caus	sed the death.							Approximate
. =	Physician	2.00	shock, or heart failure. List ont	y one cause on each	Alama	10	-100	R.	000			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Dusto for	s a conseque	ence of):	Lecro	ge Ba			0	Lyears
	Examiner		1					ी				J
	S. 51	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseque	ence of):						
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6								
o î	exec an an rial-tr		resulting in death) Last	Due to (or	as a conseque	ence of):						
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٥	death certificate be executed e attending physician and id for use as the burial-transit	fed	IE EE WIE									
X Q Q	th cer endir r use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1∏Live birth	me of pregnan 2 D Fetal o		Ectopic pregnancy				of delive	
	deat	sicie	in the past 12 months?		at time of dea		Other (specify)			Mor	ith	Day Year
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ś	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to deat	n but not resul	ting in the ur	iderlying cause give	en in Part I.				e cause of death?
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Vital	sician: The lav certificate has rrector, page 2	Be (	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only one			
о Го	hysic his ce I dire	2	1 ☐ Yes 2 No	Hospital: 1 Inpa	atient 2 E	R/Outpatien	t 3□ DOA Othe	er: 4 Nursing Ho	me 5 Resider	nce 6 Othe	er (Specify	r)
	ng P	ü.	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of I	njury Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how	w injury occurr	bd	-
<u> </u>	endi eath. or: A the fu	atl	2 Accident Investigati				M 1 🗆 '	Yes 2 □ No				
DIVISION	ter d irect irect n by	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	a 286 Place of	Injury - At honetc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		er or Rura	l Route Number,
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	To the Mospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific Completely filled in by the funeral director.	cal	(Check only 2   Medical Exa	Physician: To the beaminer: On the basis	s of examination	riedge, death on and/or inv	occurred at the time estigation, in my or	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and ma te and place, a	nner as st ind due to	ated. the cause(s)
	thin 2 thin 2 the mple	Med	29b. Signature and title of certifier	and manner	stated.		29c. License	number	20	d. Date signied	(Month:	Dav. Year)
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(	40		30. Na - and ddress of per-oll wh	completed cause of	of death (Item :	23a) (Type.	Print)	(1)	Sa. 1	147 c	EEDS	211/2
	Sta	to	31. Date filed (Month, Day, Year)	32 Reg	strar's Signatu	ıre	1. (10)		AND L	11111	VLV	0.000
15°-26	Registr				news	1. 1	barker	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 7:10 P M CHRIS DANIEL TOME April 27 2009 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday, 65 Maryland 12/27/1943 215-44-2138 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2√ No Harford Street Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3624 Scarboro Road 21154 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 □ Mever Married 2 □ Married 1 ☐ Yes 🗱 No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Laborer 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christopher D. Tome Gladys Grove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Brookside Drive, Perryville, MD 21903 George C. Tome/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Shenberger's Ch.Cem. 5/1/2009 Red Lion, PA 21. Signature of Fureral / rvice Ligense 22. Name and Address of Facility 17314 Harkins Funeral Home, Inc., Delta, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxic and Hypercopnic Respiration 1 day Due to (or as a consequence of): I day Accide Colonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner COPD Exacerbation Due to (or as a consequence of): Pneumenia Physician/Medical (Recurrent IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Ble Chronic ARI Hypertacelemia Hypomatremia Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 ☐ Yes 2 ☑ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 1 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

6 ☐ Could not be

(Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date and place and place and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number 00065641 29d. Date signed (Month, Day, Year) 04-27-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kameel Bangonia, M.D.

BANGORIA

500 WPPER CHESAPEAKE DRIVE UPPER CHESHPEAKE MEDICAL CENTER. BELAIR

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

**Funeral** 

Director

filed within 72 hours after death with the Maryland Hygiene.

Pages 1 and 2 should be 1 nent of Health and Mental 3 ant: If item 27 is marked o

Important: If it any injury or o

Physician

/Medical

Examiner

burial-tran

certificate

Director:

within 24 hours are. ...
To the Funeral Director

Medical

Hospital or Attending Physician: 24 hours after death.

Maryland

Baltimore,

Box

P.O.

Records,

Division or Vital

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Ex-miner must be notified at

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 16, **Physician** WILKINS SAUNDRA April 2009 6:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince George's Future Care Pineview Nursing & Rehab. Ctr. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🖼 F Days Hours Director 214-58-1077 D.C May 25, 1952 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any filury or other traumatic event; the theolical Examiner must be notified at alones. 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits Director 1 ☐Yes 2 No MD Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9106 Pine View Lane 20735 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Payroll Supervisor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edgar Wilkins ၉ Lucille Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Tolson - Sister 2140 Adelina Road, Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 4/24/2009 Clinton, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Blady U. Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. The forms a consequence of the condition Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Elbrilation Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and pertension the burial-transi Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ 9 ☐Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 Z No 2 🗆 No of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D 1 EcrtifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

de

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifig

Bahram

Pishdad M.P. 31. Date filed (Month, Day, Year) 32. Registraris Signature APR

22 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328. Southern Ave. SE, Ste. 310

29c. License number

D 51520

Washington, D.C. 20032

29d. Date signed (Month, Day, Year)

04-17-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#29c per Phy 4/29/2009 AA Co. Health lo State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** April 2009 6:45 A M Beth Maxine Woolverton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Charlestown Care Center Catonsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7/16/1913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 95 UT 528-32 2703 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner in the Levilled at 1 ☐ Yes 2 No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 709 Maiden Choice Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2**XX**No Specify Specify ð White 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Army Budget Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beth Woodhead William Fahrni ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 928 Bayberry Drive, Arnold, MD 21012 William T. Hatch - Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4/21/2009 Baltimore, MD Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 147 Duke of Gloucester St, Annapolis, MD 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical use as 1 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2.☐No ours after death.

eral Director: After this certificate has been signed by the ifiled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Funeral I 29a, Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 00020040 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 110 all James R. Evans MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 vans 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11:30PM 18, 2009 ALVIN R WATKINS April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Golden Living Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JAN. 17, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 □ F 577-28-0547 88 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla beperfroment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a freafter Examiltant to a routified. 1 XYes 2 □ No Maryland Frederick Frederick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 100 Mount Olivet Blvd. 21701 United States by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Affiled Folces: 1 Mayes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Signalman Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvester [ ] Watkins Helen Buxton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maizie Watkins / Wife 100 Mount Olivet Blvd./ Frederick, Maryland 21701 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 104/22/2009 Frederick, Maryland Mount OLivet Cem. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): 1621 Opossumtown Pike/ Frederick, MD 21702 Approximate Interval Between Onset and Death **Physician** MINITHS /Medical MONTHS **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) physiciar Physician/Medical the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy After this certificate has been signed by the atte funeral director, page 2 should be detached for t Month 5 Other (specify) ☐Yes 2☐No 9 I Inknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1XYes 2☐No Division of Vital Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Name and address of persol who completed cause of death (Item 23a) (Type, Print) PRIO ERICK,

12+1

State Registrar 31. Date filed (Month, Day, Year) APR 21

MD 196 TJOLIVE 32/Registrar's Signature

Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | 1 0 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month April 09, 2009 10:22 Am **Physician** Marian C. Wahle /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 6407 Hillmeade Road Bowie 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 22, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 X F South Dakota Ĩ923 Yrs 86 Director 519-14-5750 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 28a-f show s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "sedent Event than it and by in this 1 and 1 1 XYes 2 No Director Prince George's Bowie Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20720 6407 Hillmeade Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? □Yes 2 Yes, Give 2**X** No 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Dixon Robert Cash ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6407 Hillmeade Road Bowie, MD 20720 Philip J. Wahle/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place George Washington Cemetery 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/20/2009 Adelphi, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) tension Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (o. a. a consequence of): ner burial-transit Exami and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv performed? Yes 2 No 2 No certificate 1 □Yes after death.

Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 2 No 1 🗌 Inpatient 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide filled i 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the 29d. Date signed (Month, Day, Year) State Registrar

09-03370 Dennis Willey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hydiene

ennis Willey	1-	State of Maryland / Department of Health and Merital Hygi  - For State  Certificate of Death	Reg. No. 20	19 1450
Dharisian	Re	Registrar  2. I	Date of Death	3. Time of Death
Physician/ Me 1 Examine		Dennis Michael Willey Jr. A	Month Day Year April 26, 2009	2315 hrs
	48	4a. Facility Name (if not institution, give street and number)  4b/City, Town, or Location of Death	4c. County of Death Wicomico	
		Peninsula Regional Medical Center Wicomico	B. Date of Birth (MM/DD/YYYY) 9. Birth	holace (State or Foreign
Funeral	5.	Months Days Hours Min.	Co	untry)
Director		213-82-6309 1 M 2 F 42 Yrs.	5-8-1966	mu
any	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
<b>*</b>		MD Worcester Stockton		1 Yes 2 No
Maryland or 28a-f show fied at once.	1	10e. Street and Number	10g. Citizen of What Cou	ntry?
the Maryland a or 28a-f sh tiffed at once		1459 Train Station Rd. 21864	U.S.H.	
the Maryland items 23a or 28a-f sho ust be notified at once numeral Director	1	11. Manital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specific Cuban Mexican Puerto Ric	ify Yes or No- can, etc.) 14. Race - Amer White, etc.	ican Indian, Black,
or items 23	<b>[</b> ]	1 Never Married 2 Married 1 Yes 2 No		hite
ral", o	- I	3 Widowed 4 Divorced of Specify:  15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of work)  17. Decedent's Usual Occupation (Give kind of work)		industry
hours after "natural", Examiner		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  College (1-4 or 5+)	(1)	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Media	3 1	17. Father's Name (First, Middle, Last)  18. Mother's Name (F	irst, Middle, Maiden Surname)	0
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D 21 should and Me 7 is ma	- 1 .	C L C L C L L C L L C C L L C C L C	And. Stockton.	
Baltimore, MD 21215-0036  pennit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene Importment of Health and Mental Hygiene Importment of Health and Mental Hygiene injury or other traumatic event, the Medical Examiner must be notified at once To Re Commleted by Funeral Director		20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City o	
ore lore lore lore lore	П	1 Burial 2 Cremation 3 Removal from State crematory or other place)	109 Exmore	NA
Baltimore, permit Pages I a Department of He Important: If ite Important: If ite Important or other tr	1/2	4 Donation 5 Other Specify: UCCChannoth Trimater 5 11 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	inco-agin	PA 23336
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Box 68760, e death certificate be the attending physici ed for use as the buri	Ž,	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy	230. Date of delive	ery Day Year
68 certiff certiff nding ise as	ian '	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify)		,
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	by P		23e. Did tobacco use contribute  1 Yes 2 No 3 Pe	
S, P.O.	<u>р</u>	Chronic alcohol abuse; diabetes mellitus;		autopsy findings available
ial Records: ian: The law requi certificate has been	Completed	Chronic renal disease		o completion of cause of
Reco	Ē		1 🗸 Yes 2 No 1 🗸	Yes 2 No
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Division of Vital Records, ral or Attending Physician: The law requirers after death.  "al Director: After this certificate has been seled in by the funeral director, page 2 should	ပု	1 Ves 2 No Impatient 2 Vertoodpatient 3 So. Injury at Work?	28d. Describe how injury occurred	
n of \ding Phy. h. After the funeral	ë.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		
Sior Attend r death ector: by the	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or	Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State)	
Hospi 24 hou Funei tely fi	<u>a</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and Check only	due to the cause(s) and manner as s	tated.
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be deach	Medical	(Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	t the time, date and place, and due to	
	ž	29b. Signature and title of certifier 29c. License number O.C.M.E.	April 27, 2009	energy, conj
		( therefore)	7,5111,217,2000	
12		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01	
Sta	ate	a 31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Regist				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Audrey Marie Wetzel 0409 0550 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS BRADDOCK CAMPUS ALLEGANY CUMBERLAND Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Months Hours Days 81 Star Tannery Director 227-38-7904 Virginia 10d. Inside City Limits Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 🛛 No Director traumatic event, the Medical Exactings rust be notified Mineral Keyser 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö USA 23a HC 84, Box 23 26726 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items, 11. Marital Status 72 hours after 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 X No Specify. δ Specify: 3 ☑ Widowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 1 and 2 should be filed wi Health and Mental Hygier IM 27 Is marked other th unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be She11 Maude ပ္ Dewey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Keyser, WV 12 N. Main Street, Apt. 105 26726 Sharon Houdersheldt/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory Cumberland, MD 21. Signature of Fugeral Service License 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) acute **Physician** days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician Physician/Medical the use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy P in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1∐Yes 2∏XNo the detached 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 2) 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

Box 68760, P.0. Division of Vital Records, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of To the

Baltimore, Maryland 21215-0036

Jesus

(Check only one)

and manner stated. 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2009

Broad

22. Registrar's Signature

MD

21244

State Registrar

Medical

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 12347 PM 10,200 tori Thelma Dorothy Zaiser 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Lanham Doctors Community Hospital 9. Birthplace (State or Foreign Country)
Pa. If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 💢 F 85 January 11,1924 192-18-4095 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 □ No Maryland Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20715 USA 12505 Kembridge Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 □Yes 2XXXIIO If Yes, Give 45-46 Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Baharka Frederick Graff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12505 Kembridge Drive, Bowie, Maryland, 20715 James E. Zaiser/Husband 20b. Place of Disposition (Name of cemetery, crematory or other pla Maryland Veterans 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State 04/16/2009 Crownsville Cemetery 22. Name and Address of Facility 21. Signature of Fundal S Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland, 20715 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

ģ

Completed

Be (

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, It we died Exander must be a cities and injury or other traumatic event, It we died Exander must be a cities and

Baltimore, Maryland 21215-0036

and burial-trar attending physician for use as the buria signed by the a d be detached for has

Physician/Medical

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Completed

Be (

Certification: To

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier (Check only one)

law requires that the death certificate be executed To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate h completely filled in by the funeral director, page

Division of Vital Records, P.O. Box 68760,

Medical State

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation

and manner stated.

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29b. Signature and title of certifie

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Syste B216, Come

rnest Anderson	State of Maryland / Department of Health and Mental Hygiene  1-For State Certificate of Death	Reg. No. 2009 1451
Physician		Death 3. Time of Death
Medical Examine	Chinest Russelle Thiades	0, 2009 2115 hrs
	4a. Facility Name (if not institution, give street and number)  Anne Arundel Medical Center  4b. City, Town, or Location of Death  Annapolis	Anne Arundel
Funeral		f Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	314-46-3296 1 M 2 F 60 Yrs. Months Days Hours Min. 11	-30-1940 Country) MARYLand
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
<u>*</u> *	all DO Amapolia	1 Yes 2 No
Maryland 28a-f show d at once,	106. Street and Number  106. Street and Number  107. Zip Code  21401	10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.		USA
th with ems 2.	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
r mus	3 Widowed 4 Divorced II Yes Give Year 11 Yes 2 Mo Specify	Specify: Black
"natural" Examin	45 December 10 Function (Capiting light stands completed) 150 December 1 level Occupation (Cive kind of work done	16b. Kind of Business/Industry
16 n 72 h n 72 h ical Es	Elementary/Secondary (0-12)  College (1-4 or 5+)  17. Father's Name (First, Middle, Last)  College (1-4 or 5+)  College (1-4 or 5+)  18.Mother's Name (First, Middle, Last)	FLOREST
15-0036 filed within 72 Hygiene ed other than to the Medical to the Medical Comples	17. Father's Name (First, Middle, Last)	die, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	# Arnest R. Anderson Angelin	A Meache
D 21 hould and Men is man	2 19a. Informant's Name/Relationship (Type, Print ) // 19b. Mailing Address (Street and Numb or Rural Route	Number, City or Town, State, Zip Code)
ore, MD 2shous 1 and 2 should feel the and 1 liften 27 is retreatment to the traumatic	Losal E Anderson 1947 Foxest Snive .  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date	Annapolis Md. 21401  20c. Location - City or Town, State
SS 1 SS 1	1 Burial 2 Cremation 3 Removal from State crematory or other place)	3 Sexeron, und
Baltimo permit. Page Department Important: injury or ot		35 ME Hopolitan Chepel
D P P III	19-11-1 Miller 1839 N. Broadway	Balto. Md. 21913
Physician /Medical	Z3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator failure. List only one cause on each line.	y arrest, shock, or heart Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Death
	Sequentially list conditions, b	
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
ed sait	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The law requires that the feath certificate be executed the Funeral Director. After this certificate has been signed by the attending physician and apletely filled in by the funeral director, page 2 should be detached for use as the burial - transition of Certification. To Be Completed by Divisional Macdical Experience of the page 2 should be detached for use as the burial - transitional Certification.	UNPENDED d.	
760, cate be physici he buri	F FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
tox 6876 eath certificate eath certificate stending phy for use as the l	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Day Year
Box 687 death certifics the attending p d for use as th	UNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not resulting in the underlying cause given in Part I. 23e. II. 23e. III. 24e. III. 24	- 1
that the date the detached		Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 ✔ Unknown
S, P	124a V	Was an 24b. Were autopsy findings available
cords, law requirements been a 2 should	<u></u>	autopsy prior to completion of cause of death?
tal Rection: The lectificate		/es 2 No 1 ✓ Yes 2 No
Vital E ysician:	examiner? Hospital: Other: Other: Other:	Residence 6 Other:
ding Phy. After th	27 Manney of Dooth 28n Date of Injury 28h Time of Injury 28c Injury at Work? 28d Dece	ribe how injury occurred
sion trendi death. ctor: y the f	1 V Natural 5 Pending 1 Yes 2 No	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the outs Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detacted outside the contributed by Description: To Re Completed by Description:	To Suicide to Could not be or To	ion (Street and Number or Rural Route Number, City wn, State)
Ilospiit 24 hour Rely fill		cause(s) and manner as stated.
Divisor To the Hospital or A within 24 hours after To the Funeral Dire completely filled in boddical Cortifical Cortifica	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	date and place, and due to the cause(s)
		29d. Date signed (Month, Day, Year)
	Pate Un- Polle to O.C.M.E.	May 1, 2009
2)/	30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201
Stat		
Registra	ar MAY 06 2008 Chave B. Jacks	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 28, 2009 **Physician** 4:13 ам Barbara Ann Alston /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 29,1950 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🖾 F 58 081-44-2664 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at YYes 2 No Director MD Prince George Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 20707 7664 North Arbory Way Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 14. Race - American Indian, Black White, etc. 72 hours after 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: African-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 ☑ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 2 should be filed w and Mental Hygier Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Poche Fred Gaines ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar 7664 North Arbory Way, Laurel, MD 20707 Sherell Alston/ Daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State May Odenton, MD West Arundel Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee J. Ken Skile. M01053 313 Talbott Ave., Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a. Hypotension disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 5 days b. Severe Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter third-righting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed Exami c. Stapholococcas Areus Pneumonia and burial-tran Due to (or as a consequence of): attending physician Box 68760 Physician/Medical Cardiac Infarction as the l IF FEMALE nse yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Ď Year in the past 12 months? 1 ☐ Yes 2 🖺 No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a I be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ፩ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 L Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2XNo 24a. Was an has autopsy perform certificate 2X No of Vital 1 ☐ Yes Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No hpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: Division 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ÆÆcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 26,2009 D67418 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD, 7300 Van Dusen Road, Laurel, MD 20707 Olalekan Peter Olufemi 31. Date filed (Month, Day, Year) MAY 0 6 2009 . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 5, 2009 Yea 2:07 Physician Рм Frank Santo Alisea /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center for Hospice Towson If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours XXM 2□ F 08/08/1942 219-40-6608 Maryland 66 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Maryland Baltimore Essex Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21221 4 Riverside Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No 1968—
If Yes, Give
Year or Dates: 1981 Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Serviceman U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Evelyn Creager Elmer Alisea မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Riverside Road, Baltimore, Maryland 21221 Daisey Alisea (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 05/08/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Runeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Figure the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme tine Cause (Final disease or condition Vectal KAK **Physician** realiting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and -trar Due to (or as a consequence of): physician a the burial-O. Box 68760, Physician/Medical as signed by the attending I IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 D Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been s page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗹 2 No this certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Attending Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No al or Attendi s after death. I Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number Balto ind Zizox 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St.

State Registrar

31. Date filed (Month, Day,

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GAMIC 32 Registrar's Signature

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 1 RV SHLE 4b. City, Town, or Location of Death 4c. County of Dea Facility Name (If not institution, give street and number, BURNLE BALTIMORE WASHINGTON MEDICAL GLEN ANNE+ STOING ENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) Aug. 28,1915 Social Security Number 7. Age (In vrs. last birthday) Days Min 1 ☑ M 2 □ F North Carolina 162-09-3203 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Carroll Woodbine Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5934 Woodbine Road 21797 United States 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify. White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States 12th <u>Operator/Engineer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ira Fulton Ashley Minnie Hartsog 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1313 Gatwick Road Glen Burnie, MD Darlene Franklin Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park May 8, 2009 Sykesville, Maryland 4 Donation 5 Other (Specify) <sup>22.</sup> Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P A 1212 W. Old Liberty Road Winfield, MD 21784 21. Signa ur of Funeral Service Lice see Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. neum onia Im nediate Cause (Final dis ase in condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseas of i jury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No 9 I I Inknown

Physician: The law requires that the death certificate be executed burial-trai Division of Vital Records, P.O. Box 68760, attending for use certificate has been signed by the rector, page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certifict completely filled in by the funeral director, I

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

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Examiner

Be Completed by Physician/Medical

Certification: To

Medical

**Funeral** 

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Madical Examiner must be notified at

the Maryland

1 and 2 should be filed within 72 hours after

Health and Mental Hygiene. em 27 Is marked other than '

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr

**Physician** /Medical

Examiner

Maryland 21215-0036

Part II. Other signific	cant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2 [	se contribute to the cause of death? ☐ No 3☐ Probably 4 ☐ Unknown				
					24a. Was an autopsy performed? 1 □Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referre	ed to medical			26. Place of Dea	ath (Check only one)					
examiner? 1 ☐ Yes 2 🗹	No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗆	DOA Other: 4 Nursing H	lome 5 ☐ Residence 6	ne 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,				
29a. Certifier (Check only one)	1  Certifying Ph 2  Medical Exan	nysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)				

30

State Registrar 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) Mey 5, 2009

mpleted cause of death (Item 23a) (Type, Print)

301 Mospital Drive, Glen Burnie

Day, Year) 31. Date filed (Month.

State Registrar

31. Date filed (Month, Day, Year) MAY 0 6 2009 DHMH 17 Rev 1/200

21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3640

RIDA A. FRAYIHA

09-03445	
Anthony Bryant	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nulony bryant		Amend Streets W27,289, Department agggreen aggreen agggreen agggre	451
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year	
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Sinai Hospital  4c. County of Death  Baltimore	
Funeral Director		WIT 0 1 3011.	or D
d now any		Bo Himme	City Limits
th the Maryland 23a or 28a-f show notified at ones.	Director	10e. Street and Number 3448 Reisterstown Road 21215 USA USA	
r death with the Maryland or items 23a or 28a-f sho must be notified at ones.	Funeral [		3lack,
urs after de itural", or aminer m	à	Wildowed 4 Divorced in res, Give year 1 Yes 2 No specify: Specify: Specify: Or Dates:	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  Station Attendant  Bus Compar	١٧
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Willie Bryant Elizabeth Washington	
MD 2 nd 2 shoul salth and M sm 27 is m	2	19a Informant's Name/Relations ip (Type, Print)  19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, Ste, Zip Code)  19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, Ste, Zip Code)  19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, Ste, Zip Code)  19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, Ste, Zip Code)  19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, Ste, Zip Code)  19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, Ste, Zip Code)  19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, Ste, Zip Code)  19c. Mailing Address (Street and Number or Rural Route, Number, City or Town, Ste, Zip Code)  19c. Mailing Address (Street and Number or Rural Route, Number of Ste, Zip Code)  19c. Mailing Address (Street and Number or Rural Route, Num	244
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at ones		1 XBurial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: Wt. Zon Cemetery 5.6.09 Baltimore,	MD
		21. Signature of Fineral Services  22. Name and Address of Fallit Greene Funeral Services  23. Signature of Fineral Services  24. Day in File (21229)	ento Interval
Physician /Medical `xaminer		failure. List only one cause on each line.	ate Interval Onset and eath
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
uted ud ansit	Examiner		
760, icate be executed physician and the buriat - transit	Medical	UNPENDED AMENDED	
O.O. Box 6876 that the death certificat ned by the attending phy detached for use as the			Year
P.O. Es that the case that the case detached	à	1 Yes 2 No 3 Probably 4	
ords, law require has been si 2 should b	Completed	24a. Was an autopsy findin autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2	of cause of
ital Rician: T	å	25. Was case referred to medical examiner?  Hospital: A post of Death (Check only one)  Hospital: A post of Death (Check only one)	
ion of Vital Rectending Physician: The Peath.  con: After this certificate Informeral director, page	tion: To	1 V Yes 2 No 220 Date of Injury 200 Date of Injury	
Division of the properties of	Certification:	Accident  Apr 29, 2009  Apr 20, 2009  Apr 20	umber, City
Divisi  To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical C		
F § F 8	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Ye.  O.C.M.E.  May 1, 2009	ar)
		30. Name and address of person who completed cause of death (Item 23a)  Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
S: Regis	tate trar	WIV D C DODO V	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar		ertificate of			iene <sub>sg. No.</sub> 2009	14518
	Dhusisi		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death	h Day Year	3. Time of Death
_	Physici /Medic				Albert Be			May 0	1, 2009	9:30 P M
	Examin	er	4a, Facility Name (If not institution, give				r Location of Death		4c. County of Dea	
	Euparal		Cherry Lane Nursi  5. Social Security Number 6. S		In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director		578-20-8953	<b>X</b> XM 2□ F 8	5 Yrs.	Months Days	Hours Min.	(Month, Day, Apr 5,	1924 Was	shington, DC
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits
	Maryl -f sho	to	MD Prince	George	Laurel					1 X Yes 2 ☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What Co	ountry?
	th wit		9001 Cherry Lane			20708		Ţ	U.S.A.	
	r dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ont, It a Medical Examirse must be reaffied at	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ∐Yes 2 📉 No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify: Whi	ite
21215-0036	2 hou	Completed	15. Decedent's Ed	lucation	16a. Dec	edent's Usual Occup	pation	ing.	16b. Kind of Business	
218	thin 7 ne. tan "n	nple	(Specify only highest gra	College (1-4or 5+)	life.	e kind of work done DO NOT use retire	during most of work d)	ing		_
2	led wi lygier her th	Co	9		Plur	nber	18. Mother's Name	- (First Middle A	Apartment	Complex
Maryland	l be fi	Be	17. Father's Name (First, Middle, Last)  Robert H. Beach					E. Ridge	,	
Ž	should nd Me mark matic	은	19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	ling Address (Street	l		; City or Town, State,	Zip Code)
<u>8</u>	nd 2 s alth ar 27 is rrtrau		Robin Curtin / st			•			e, Marylan	
Je,	of Hear Item		20a. Method of Disposition		20b. Place of Disc				20c. Location - City or	
<u>=</u>	Page ment ant: If ury or		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		el Cremat	1	5, 09	Odenton, M	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Madical Examinst Le profilled all once.		21. Signal re of Funeral Service Livin	V//	1	22. Name and Addre Donaldson 313 Talbot	Funeral E	Home, P.A	A. aryland 20	707-4389
			23a. Part 1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the	e death. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
-	Physician		Immediate Cause Final disease or condition	Prus	tate	Cance	4			Onset and Death
زر	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):	- 32				
	- LAGIIIII CI	-e	Sequentially list conditions,	b Due to (or as a c	onsequence of):					
W	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540 10 (0) 40 4 0	ondoquando oi).					
0	an and	Еха	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
68760,	ificate be executed g physician and is the burial-transit	edical		d						
		Med	IF FEMALE:		N-7.85					
Box	eath certification attending processes	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death 3	☐ Ectopic pregnand	су		23d. Date of de Month	elivery Day Year
o.	The law requires that the death cort ate has been signed by the attending age 2 should be detached for use a	Physician/M	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknown	ne or death 5	Other (specify) _				
ď.	s that jned b e deta		Part II. Other significant conditions of				ven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
ğ	w require s been sig should b	ed b	Chronic Ler	LA.	sur their			1 □ Ye	es 2₽TNo 3□P	robably 4 Unknown
Vital Records,	e law re has be ie 2 sho	Completed by	Dementer,			1		24a. Was ar autops	n 24b. Were a	utopsy findings available completion of cause of
<u> </u>	Physician: The le r this certificate ha ral director, page 2	Com						perform	ned? death?	
/ita	iclan: sertific setor,	Be (	25. Was case referred to medical examiner?	11		100	26. Place of Deat			
of	Phys this al dir	<u>면</u>	1 Yes 2 No	Hospital: 1 ☐ Inpatient  28a. Date of Injury	2 ER/Outpati	ent 3 LI DOA			ence 6 Other (Spensor Injury occurred	ecify)
Division of	ling Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Y	(ear) Injury	Wor	rk? ]Yes 2□No	Zou. Describe no	w injury occurred	
S	I or Attendi after death. Director: A d in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, s				reet and Number or F	tural Route Number,
á	tal or s afte al Dir ed in	Certification: To	4 ☐ Homicide determined	building, etc. (	<i>Зреспу)</i>			City or Towr	i, State)	
<b>h</b>	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical (		ysician: To the best of r niner: On the basis of ex and manner stated	kamination and/or					
9	To the To the Comp	Me	29b. Signature and title of certifier	211		29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
			· Marine	there		00	53235		May 4, 20	09
			30. Name and address of person who Darryl Hill	completed cause of deat			el, MD 207	707		
	Sta		31. Date filed (Month, Day, Year)	321 Registrar's	Signature					
	Registr	ar		0 /	1 60	ake				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 02 Physician 2000 0000 A M John George Benny /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square
5. Social Security Number | 6. HOSPItal Batimore Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 F Yrs. Director 1/19/1921 Maryland <u>214-16-5221</u> 88 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinat must be motified at 1 ☐Yes 2 No Director Maryland Baltimore Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U. S. A. 5 Bothwell Garth 21236 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 14. Race - American Indian. Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Sanitation Engineer Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ <u>Madeline</u> Benny <u>Katherine</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Madeline Rose Buchanan (Daughter) 5 Bothwell Garth Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 568<sub>9</sub> 4□Donation 5XiOther (Specify) Entombment Gardens of Faith Mem. Gard. Overlea, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Mucus plugging into Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con whence wh) Examiner proumonio Spiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed schemic cardiomyop ending physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NSTEMI, recent 1 Yes 2 No 3 Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed this certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mary er of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 V Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No s after death.

I Director: A in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

within 2 To the the

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklin Square Dr. Baltimore, MD 21237

29c. License number

29d. Date signed (Month, Day, Year)

5/2109

State of Maryland / Department of Health and Mental Hygiene [] [] 9 Certificate of Death Reg. No.

Physician
/Medical
Examiner

1 - For State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a five less cincumstice and once.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

an	Decedent's Name	o (i not, imaan	0, 2001/								Month		Day	Year		Death		
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	5. Social Security N		6. Sex 1 ☐ M 2		Age (In yrs. la 9		Month	er 1 Year s Days	Hours	Min.		Day, Yea		Cou	intry)	or roreig		
	213-42-64 Usual Residence of										April	19, 1	1911	MIC	higan			
_	10a. State	10b. County		-	10c. City	, Town o	r Location							10d. Inside Ci				
ğ	Maryland	Mon	ntgomen	Э	S	andy	Sprin	ıg			1 🗆					2 🔀 N		
lre	10e. Street and Nu	mber					10f. Z	Zip Code						f What Cou				
<u>a</u>	17340 Qua	aker La	ane					0860						Stat				
nue	11, Marital Status		Ar	med Forces		5.	13. Was Dec If Yes, sp	cedent of Hoseify Cuba	lispanic O an, Mexica	rigin? (Span, Puerto	ecify Yes or Rican, etc.)	No-		ace - Amer ack, White	rican Indian, , etc.			
by Funeral Director	1 Never Marr	If '	1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: Year or Dates:					y:			Spec	<sub>iify:</sub> Wh	ite					
ed le	3 🗆 Wildowed		nt's Education			16a. D	ecedent's Us	sual Occup	ation			16b	. Kind of I	Business/I	ndustry			
pie	(Spec	cify only highe	est grade com	pleted) ollege (1-4o	or 5+)	(C	Give kind of v ife. DO NOT	vork done o use retired	during mo d)	st of work	ing							
Be Completed	Elementary/Seco		Te	acher								ernmen	t					
	17. Father's Name (First, Middle, Last)						18. Mother's Nam						den Surna	ame)				
0	Charles	Ackerma	an								Thras							
	19a. Informant's N David F.			rint)		19b. N	Mailing Addre	ess (Street	and Numb	ber or Rur Gam	al Route Nu brills	mber, Ci S • M	ity or Tow D 210	n, State, Z <b>)54</b>	Zip Code)			
			7 5011		OOb D		Disposition (A				Date				Town, State			
	20a. Method of Dis	Cremation		al from Stat	_ C	emetery,	crematory o	r other plac	ce)	May 3	3, 2009	9		-				
	4 □ Donation	_			Kes	Stila				ility					Maryla:			
	21. Signature of Fi	uneral Service	Licensee				Rest	havei	n Tü	mera	ıl Se	rvi	ces,	Skk	ot Cody	y P		
- 1	To Ports English	The decree of	r complication	ns that caus	sed the death									eric	Approxima	te		
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09-03536 Joy Bush

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		1- For State Registrar	tato or Maryland		icate of D	eath			Reg. No	20	09 1432
Physicia ledical Examir	n/	1. Decedent's Name (First, Midd Joy	, and the second	elle		Bus	sh	2. Date of D Month May 2, 2	Day	Year	3. Time of Death 1547 hrs
)	Ĭ	4a. Facility Name (if not institution			4b. (	City, Town, or				c. County of Dea	_L
		Saint Agnes Hospital				altimore					
Funeral Director		5. Social Security Number		e (In yrs. last	N	Under 1 Year fonths   Days		Min	,	Fore	Birthplace (State or eign
Director		217-06-8255 Usual Residence of Decedent	1 M 2 X F	24	Yrs.			07	11_	84	Country) MD
*ny	ŀ	10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Limits
<u> </u>	٦	MD N	A	E	Baltimo	re					1 X Yes 2 No
Maryla 28a-f d at or	Director	10e. Street and Number			10	f. Zip Code			10g. Ci	tizen of What Co	untry?
th the 23a or notifie		3801 West 0					.215			U.S.A	
ath wi items	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Decedent Armed Forces?					gin? ( Specify Yes or , Puerto Rican, etc.)	No-	White, etc.	erican Indian, Black,
ffer de		3 Widowed 4 Dir	1 Yes 2  Vorced If Yes, Give Year or Dates:	X No	1 Ye	2 X No	specify:			Specify: E	Black
1215-0036 Id be filed within 72 hours at fental Hygiene. narked other than "natural event, the Medical Examin	eted by	15. Decedent's Education (Spe	ecify only highest grade com	, ,		Isual Occupat		kind of work done use retired)		Kind of Business	s/Industry
36 in 72 han "dical E	plet	Elementary/Secondary (0-12)  12th grade	College (1-4 or 5	5+)	-	shier				ods	orting
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218 be fill ental H rrked	Be	Rolando Bus						ina Alle			
D 21 should I and Mer 7 is man	۴ļ	19a. Informant's Name/Relations			N -	,		nber or Rural Route Move Palt		-	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ŀ	Regina Pric	igen-Mother	20b. Pla	ce of Disposition	(Name of ce		Date		Le Figure 1910	
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 X Burial 2 Crematio			matory or other			5/9/09	Ва	altimor	re, Md
altin mit P partme portar		4 Donation 5 Other S 21. Signature of Funeral Service			22. Nam	e and Address	s of Facility	v			
E E E E		23a. Part I. Enter the disease, o	arch		Marc 4300	h F/H Waba	sh A	Ave, Bal	timo	ore, Mo	21215
Physician /Medical		23a. Part 1. Enter the disease, o failure. List only one cause	e on each line.		o not enter the r	node of dying,	, such as c	ardiac or respiratory	arrest, si	hock, or heart	Approximate Interval Between Onset and Death
xaminer	ı	Immediate Cause (Final disease or condition resulting in death)	e a Multiple Injuries  Due to (or as a conse								Death
		Sequentially list conditions,	b								
	lie lie	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):							
isi e //	Examiner	(Disease or injury that initiated events resulting in death) Last		equence of):							
tra and ecut		UNPENDED	damended								
760, cate be ex physician he burial	Medical	IF FEMALE:	23c. If yes, outcom	me of pregnar	ncy	_	-		2	3d. Date of deliv	ery
		23b. Was decedent pregnant in t past 12 months?		time of death	2 Fetal		Ectopic	c pregnancy		Month	Day Year
Box 68 death certif	Physician	1 Yes 2 No 9 V Ur			5 Other	(Specify)			1		
- 50	by Pł	Part II. Other significant condi	itions contributing to death	h but not resu	ulting in the unde	rlying cause	given in Pa				to the cause of death?
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ing Phy ing Phy After thi funeral d	2	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ırv 2	8b. Time of Injur		ary at Work	28d. Descri	be how i	njury occurred	
<b>~</b> ± . ^ ≥	텵		nding (Month, Day Y May 2, 2009)	1	500 hrs	1	Yes 2 🗸	No Pedestria	in struc	ck by auto	
Division tal or Attendi rs after death. at Director:	Certification:	3 Suicide 6 Cou	uld not be 28e. Place of In		e, farm, street, f	actory, office I	building, et				Rural Route Number, City dsor Mill , Baltimore , M
lospita Hours Inneral	<u></u>	29a. Certifier	ermined (Specify) Loc  Physician: To the best of m		death occurred	at the time d	ate and nis	1			
Division of Vital For the Hospital or Attending Physician: within 24 hours after death. To the Fineral Director: After this certificompletely filled in by the funeral director.	Medical	one) Certifying F	aminer: On the basis of examiner and manner stated.	mination and	or investigation	in my opinio	n, death oc	courred at the time, d	ate and p	place, and due to	the cause(s)
- F 3 F 8	₹	29b, Signature and title of certification		·		29c. Licens	se number		290	Date signed (f	Month, Day, Year)
		Maryente Pr	ne Yall			O.C.	.M.E.		M	ay 3, 2009	
		30. Name and address of perso Margarita Korell MD.	on who completed cause of d Assistant Medical		,	n Street. B	Baltimore	e, MD 21201			
Sta	ate	31. Date filed (Month, Day, Year,		r's Signature							<u></u>
Regist	_	MAY 0 6 2	2009 Jenus	<u></u>	park		<del>-</del>				
DHMH 17 Rev 1/20	01				ORIGINAL						

Reg. No Certificate of Death 1. Decedent's Name (First: Middle, Last) 2. Date of Death Dav Year **Physician** Cen (0:05 AM 05 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner altimore MI If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 Maryland 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 M 2 □ F Sept. Director 218<del>-</del>46-6748 62 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Modical Examine trust be a cuttled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena Director 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1203 Holmewood Drive 21122 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Educator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Balcer Helen Kuszyk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet N. Balcer 1203 Holmewood Drive, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Mary Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-07-09 Dundalk, Maryland 21. Signature of Funeral Service License McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imprediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (of as a consequence of): Examiner Homorrha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed 50 20 m and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

10+

State Registrar

29b. Signature and title of certifier

31. Date filed

(Month, Day

Year)

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steppan

22

32. Registrar's Signature

5

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month AT BERT MALLIIW BENNETT SR. April. 30. 6:22 РМ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex Months Days 1 M 2 □ F Mary land December 27, 1946 218-44-8127 62 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Anne Arundel Glen Burnie Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4 Ridge Road 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sessa Sheet Metal Sheet Metal Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be11 Catherine Harley Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Ridge Road, Glen Burnie, Maryland Kathleen M. Bennett (Wife) 21060 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05-06-09 Baltimore, Maryland 4 Donation 5 Dother (Specify) Mc Cully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Signature of Funeral Service Licenses 23a. Pand. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical Examiner

certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

s after death.

To the Hospital within 24 hours a To the Funeral D

filled in by the I

Medical

State Registrar

**Physician** 

/Medical

10a. State

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

marked other than

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any injury or other trau

other traumatic

2 should be filed v and Mental Hygie

within 72 hours after

3altimore, Maryland 21215-0036

Examiner Physician/Medical

and burial-t attending physician for use as the signed by the a icate has been si , page 2 should t this certificate has director, funeral After

Completed Be

25. Was case referred to medical examiner? Certification: To 27. Manne Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

2 1 No

5 Pending investigation

6 Could not be

determined

23b. Was decedent pregnant in the past 12 months? □Yes 2□No

yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death

9 Unknown

3 🗆 Ectopic pregnancy 5 Other (specify)

1 Yes 24a. Was an

2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Day

Year

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1' Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28c. Injury at Work?

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28h. Time of

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mamer etated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 No

29c. License number 00005829 29d. Date signed (Month. Dav. Year)

23d. Date of delivery

Month

23e. Did tobaco use contribute to the cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA

31. Date filed (Month, Day

allure and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BROWN LAVERA 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK NORTH HAMPTON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 219-20-352 **Director** Usual Residence of Deceden the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No FREDERICK MD. FREDERICK Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the Medical Examples Investigate must be some. 21702 USA SCHAFFER Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: BLACK ģ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 6tico Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL -INSURANCE ADMIN 171 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLARA THOMAS WILLIAM H. WILSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY FREDERICK MO ZITOZ LOURDUT LANE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FREDERICE MD 2009 2. PATRVION Com. 4 ☐ Donation 5 ☐ Other (Specify) ROLLINS FUN. Home 22. Name and Address of Facility GARY L. 21. Signature of Funeral Service License sung. SI FREDERICA MO 21701 SOUTH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** E P DO VOSCUITY month disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical cate has been signed by the attending r page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown portenson 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes 2 🖟 completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 No Other: Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date

C

filed (Month, Day, Year)

DHMH 17 Rev 1/2001

6 2009 Server B. Spark

32. Registrar's Signature

Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 4, 2009 **Physician** Joseph Stephen 7:23 A M Bostwick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Briar Road Parkville 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1 ₹ M 2 □ F 1947 Maryland Director 62 216-50-4701 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, I've Medical Evaminer must be notified at 1 ☐ Yes 2 ☑ No Director Md. Parkville Baltimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21234 9002 Briar Rd. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 🗆 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, ITEM. Elementary/Secondary (0-12) College (1-4or 5+) Chief Investigator Criminal Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John R. Bostwick Lillian S. Giarrusso 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Nancy A. Bostwick/ Wife 9002 Briar Rd. Parkville, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-6-09 Hilltop Service Co. Towson, Md. 22. Name and Address of Facility 21. Signature of Fundal Ser Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final FAILURE Physician RESPI RATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Lars Examiner P Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 🗍 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SXX Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Records, P.O. Box 68760, signed by the a has After this certificate Division of Vital within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

72 hours after

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

May 5<sup>+4</sup>, 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE BEDON

and manner stated.

6701 N. Charles St. Baltinuce, Dd. 21204

31. Date filed (Month, Day, Year)

MAY 0 6 2009

To the

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 Day 200<sup>Year</sup> MAY 1:25 P M **BOSK** RUTH 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOWARD VANTAGE HOUSE NURSING HOME COLUMBIA 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Hours Months Days 1 □ M 2 🕱 F 0270771919 90 Vrs 219-01-9567 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No MD HOWARD COLUMBIA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 5400 VANTAGE POINT ROAD 21044 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify. Specify 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** HOTEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY BARR NATHAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5682 VANTAGE POINT RD., COLUMBIA, MD CAROL LIEBESMAN / DAUGHTER Date 20c. Location - City or Town, State 20a. Method of Disposition SHOMRE1 "MISHME'RES" 1 Burial 2 □ Cremation 3 □ Removal from State 05/04/2009 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) SCHARES HAPLATA SOL LEVINSON & BROS., 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 www 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or is a consequence of): disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Taukins Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an perform 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at

certificate be executed P.O. Box 68760. attending physician the use ō the þ signed t Division or Vital Records, has this

Examiner Physician/Medical Completed Be ပ completely filled in by the funeral Certification:

Physician

/Medical

**Examiner** 

Director

Funeral

<u>م</u>

Completed

Be

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Funeral

Director

show

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

ene.

12 should be filed w h and Mental Hygier 7 is marked other th

Pages 1 and 2 should be iment of Health and Menta tant: If Item 27 is marked

permit. Page Department of Important: If any injury or

**Physician** 

/Medical Examiner

or other traumatic event,

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner?

1 Natural 2 ☐ Accident 5 Pending investigation 3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

commanieath AV coxavelle de ) 2/22

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Medical

DHMH 17 Rev 1/2001

within 24 hours after death. To the Funeral Director: After

Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 14527 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:15 PM BURG AUSILEY MAI 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner North west Randallstown Hosp Hal Bultmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months 068-22-8338 79 Director 05/03/1929 Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f shores MD Director BALTIMORE REISTERSTOWN 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 REDMILE COURT 21136 USA Funeral 7 Is merked other than "natural", or Items traumetic event. It was a least Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No à WHITE Specify: 3 ☐ Widowed 4 🕱 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within the and Mental Hygiene.
7 Is merked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 SALESPERSON ENTERTAINMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT BURG ANNA KLINGON ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n eny Injury or other traunone. JAN BRANT/DAUGHTER DEAVEN COURT BALTIMORE, MD 21209 Place of Disposition (Name of cemetery, crematory or other place)
INGTON CEMETERY 05/03/2009 BALTIMORE,
IZUK AMUND CONG. 22. Name and Address of Facility SOL LEVINSON & BROS., 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funera PIKESVILLE, MD 21208 <u>8900 REISTERSTOWN ROAD,</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Separs **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner adure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificete be executed and use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the e P.O. ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Gastrointestmal 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy certificate 1 □Yes 2 No or Attending Physicien: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral dire 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier D 35844 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Old Court Road

31. Date filed (Month.

Randallitown

. Registrar's Signature

21133

mo

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Day 2009 **Physician** 26, 2:45  $A^M$ Julia Clews Arnold /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Asbury Methodist Village Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 97 25, 1911 Maryland Director 212-68-2425 Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland Montgomery Gaithersburg death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a 20877 201 Russell Avenue U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after □Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 ō Specify: White 1 ☐Yes 2 X No Specify 2 Year or Dates 3 Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Isaac D. Arnold Abbie Dishman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau 4225 Camellia Dr. S, Salem, OR 97302 <u> Hedley Clews</u> (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🖔 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/26/09 Lorton, VA 4 ☐ Donation 5 ☐ Other (Specify) Pohick Cemetery 21. Sign ture of Funeral Service Licen 22. Name and Address of Facility
Mullins & Thompson Funeral Service tus P.O. Box 3550 Fredericksburg, VA 22402 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** mont PA concer disease or condition resulting in death) /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Er ter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 🗌 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were eutopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform The 201No Division of Vital 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To he Hospital or Attending Phys in 24 hours after death. he Funeral Director: After this pletely filled in by the funeral dii After this 28c. Injury at Work? 27. Manner of Deatl 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and titl of certifie person who completed cause of death (Item 23a) (Type, Print) 30. Name and advess 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar MAY 06 2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM TO BE 196, per FH, 8892, 673/09, WS

Amend Item State of Maryland Desparation and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 1136 AM William Coffman 04 21 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner | Is a / th more, | The Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Jan. | 6, Baltimore, Shock Trauma Center 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 215-23-1725 1 □ M 2 □ F 20 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show d other than "natural", or items 23a or 28a-f shov event, the Modeal Exertimer mast be ruffled at 1 ☐ Yes 2 No Funeral Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Westway Pages 1 and 2 should be filed within 72 hours after death with 527 Westray Road 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, I'm M Plumber Plumbing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Ann Seabrease David William Coffman 2 19b. Mailing Webstw Stylet and Number or Rural Route Number, City or Town, State, Zip Code) 527 Westray Road, Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type. Print) David W. Coffman - Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Loudon Park Cemetery 4-25-2009 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. and 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Tranmatic Brown Injury 7 days > /Medical Due to (or as a consequence of): Examiner Motor Vehi de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): #28ڪ Division of Vital Records, P.O. Box 68760, Physician/Medical M. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy n in Part I. Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No : After this certification and the section of the s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗌 Natural 5 Pending investigation 10:00 P M collision 1 ☐Yes 2 No 4114109 motor vehicle 2 Accident Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after

To the Funeral Dire

completely filled in b Roadway 2400 Han over The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 21, 2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hunh Trymin Baltimore, Greene 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 29, Waryland Department 95/03/03/03/04/04/04 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month **Physician** Dorothy Crisp 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham Birthplace (State or Foreign Country)
 unknown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/06/1934 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 75 427-58-7876 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director MD Prince Georges College Park 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 4711 Berwyn House Road 20740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc or i 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 White 1 □Yes 2K No Specify Specify <u>ک</u> 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainmant. unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Burns Friend 5020 Olympia Avenue, Beltsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4□Donation 5☑Other (Specify) instate 21. Signature of Funery Service Licensee 1 S. Wade 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due tour s a consequence of): Examiner LIAC Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINE Examiner the death certificate be executed signed by the attending physician and does detached for use as the burial-trar Due to (or as a consequence of) Box 68760, by Physician/Medical 3e IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, cate has been sl page 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1 □Yes 2 No of Vital Physician: director, 25. Was case referred to medical examiner?
1 XYes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 X No 03/26/2009 Unknown M Subject fell s after death death 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4711 Berwyn House Road, College Park, MD filled in by determined 4 Homicide Home within 24 hours a

To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOX LANE SUITE 252 BOW. E. MO HOKAM.D. GALLAUT

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Manyland & Department of Health and Mental Hygiene 1 - For State Registrar 453 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** 12:00PM Beatrice Cuestino 2000 pri /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Baltingove Koad 01023 Dog wood If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F Months Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the W. digal Evan, inc. must be notified at 1 ☐Yes 2 No Baltin none Director MD Kaltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Hygiene. 21207 Koad log vy dod Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐Yes 2 No Specify ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Security Social permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other tha any Injury or other traumatic event, In. A. 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ear Goldman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Change (Husband) 6623 Dogwood Road Baltimore ND 21207 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Woodlawn, MD 25/09 Woodlawn Cemetery: 041 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of acility Vauyhn C. Seene Fur Phal Services Road Liberty Randall soun NO 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help tablure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a consequence of): **Examiner** Probable Cardiac Arrhythmia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner certificate be executed the attending physician and the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for i in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available After this certificate has autopsy prior to completion death? 2 No 1 □Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 ☐ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ≯ 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H31615 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walker Ave Beiker

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

Mange

OU 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** HANNAH В. DAGES /Medical 4c. County of Death 4b City, Town, or Location of Death **Examiner** 4a. Facility Name (If not institution, give street and number) edica Age (In vrs. last birthday Birthplace Country) or Foreian **Funeral** Hours Min. December 13,1918 1 M 2 F 90 212-07-9652 Director Maryland Usual Residence of Decedent 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified at once. 10a. State 10b Counts 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena Director 10f. Zip Code 10g. Citizen of What Country? 7818 Bodkinview Drive 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) R. Solomon John Bertha Brannan ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2140 Lake Drive, Pasadena, Maryland 21122 Deborah L. Rebstock (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 05-06-09 Brooklyn Park, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License McCally ማሪያ ያገንተለ ማመረ ያገን Maryland 21122 3204 Mountain Road, Pasadena, Maryland 21122 23a. Pan 1. Enter the disease, or complications that caused the death. mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physiclan and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending phase as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2**X**Î No icate has been sig ; page 2 should b 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate | 2 No 1 ☐ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Date of Injury 28c. Injury at Work? 1 Natural
2 Accident (Month, Day, Year) 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check enly one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Wan Brine . mo

State Registrar

e filed (Month, Day, Year)

DHMH 17 Rev 1/2001

09-03348 Roland Spencer I	1	ithan - For State	<b>lease Tyj</b> St	oe or ate of	Print ir Maryla	n Blac and / D	epartn)	nent o	<b>nk. Er</b> of Health of Death	h and	All Co Menta	opies al Hyg	jiene	egible		09	14	53
Physicia	n/	Registrar 1. Decedent's Na Roland	ame (First, Midd	e,Last)	onit	han			-,				Date of De Month April 26,		Year		me of Death 132 <b>hr</b> s	
Medical Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death										40	c. County of De Baltimore C					
Funeral Director		5, Social Securit 218 <b>-</b> 62		6. Sex	2F	7. Age (1)	n yrs. last b	oirthday) Yi	Months	r 1 Year Days	If Under Hours	24Hrs. Min.	8. Date of E 01/2	3irth(MM 29/1	(DD/YYYY) 9. . 954 Foi	Birthplac reign Country	MD	
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er death with the	Funeral	11. Marital Statu 1 Never Ma	arried 2 N	farried	2. Was Dec Armed F 1 Yes Yes, Give Ye	orces?	2		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, White, etc. White Specify:			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's	s Education (Spiecondary (0-12	ecify only	r Dates: highest gra			during	ent's Usual most of wor	Occupati king life.	ion (Give k	ind of wo	ork done ed)		Kind of Busine			Led
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more, I			Disposition  2 Cremation  5 Other		Removal	from State	l crer	matory or Sape	osition (Nar other place eake	Cre	m.	Apr 20	09	' Be	eltsvi	tion - City or Town, State SVille, MD		
Baltir permit. I Departm Imports injury o		21 Signature o	f Funeral Service	e License	H	Mo		>   8	8717	Gre	en P	ast	ures	Dr	n D.Lo . Balt	i,	MD 21	286
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Box 68760, death certificate be the attending physic of for use as the burned for use as	sici		No 9 U	Inknown	4 Preg	gnant at ti known	me of deat	h 5	Other (Spe	ecify)						1-1-16-	and of dom	·h2
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Division of Vital Records, P.O. Box 68760, other lospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Completed							<u> </u>			<u> </u>		p	Vas an utopsy erformed 'es 2	prio	ere autop or to com ath? Yes	sy findings av pletion of cau 2	ailable se of No
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			For State Registrar	State of Ma	ryland /		artmen r <i>tificate</i>				JIENE Reg. No.			
	DI dist		1. Decedent's Name (First, Middle, Last)	e, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death	
	Physician Mary Katherine Dorsey									5/3	3/2009		4:40 P M	
200	Examin	er							Location of Deat	h	4c. County of Death			
and the			2910 West Cold Spring Lane, Apt. C  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					Baltimore If Under 1 Year   If Under 24 Hrs.   8.			Sirth 9. Birthplace (State or Fores		thplace (State or Foreign	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene Important: If then 27 is an anxied other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaniner must be notified at once.			M 2 🔀 F	91	Yrs.	Months	Days	Hours Min.	8. Date of Birt (Month, Da)	( <i>Year)</i> 1917	Co	MD	
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		'n	SCA S 2 I No											
		Director	MD /// Baltimore  10e. Street and Number 10f. Zip Code								10g. Citizer	of What Co		
			2910 West Cold Spring Lane, Apt. C 21215								US			
99		Funeral		12. Was Decedent E			1			Specify Yes or No- to Rican, etc.)		Race - Ame	erican Indian,	
			1 ☐ Never Married 2 ☐ Married	Armed Forces? 1			1 ☐ Yes 2 No Specify:			to Rican, etc.)		Black, White, etc.  Specify: P1 colr		
21215-0036		d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:									Black  Sb. Kind of Business/Industry		
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/lar		To E	John Lowman Fannie Be								erry			
Maryland			19a. Informant's Name/Relationship (Ty	pe. Print)	1		•			ural Route Numbe			Zip Code)	
			Laurese Richards 20a. Method of Disposition	on/Niece_	20h Place					imore, M			r Town, State	
יסר			1XXXBurial 2 ☐ Cremation 3 ☐ F	emoval from State	1		natory or of					•		
altimore,			4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		White				netery 5				le, MD	
Ba			21. Signature if Funeral Service Licensee  22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A.  1212 W. Old Liberty Rd., Winfield, MD 21784											
	1538		23a. Part 1. Inter the disease, or complicity insithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
-	Physician		shock or heart failure. List only one cause on each line.  Imme liar Cause (Final diseas or condition resulting in death)  Due to (or as a consequence of):											
	/Medical Examiner													
	Examine	<u>_</u>	Sequentially list conditions, if any, leading to immediate	). Due to (or as a	concoguent	ce of):								
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of Vital Records,		d by									1 Yes 2 No 3 Probably 4 Unknown			
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			18411 141	/ V V F			11)	603	19/24		May	06,	2009	
ø	4 /		30. Name and address of person who co	empleted cause of de	eath (Item 23	Ba) (Type,	Print) M	aurl	nuctu.	2.1 11/10	10/16	26/01	2009 MD 2110	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registra	r's Signatu	1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		117 17/	-or AACOL	1000	1171	1 / 01/0	
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of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal must be netfilled at Pages 1 and 2 should be filed within 72 hours after death with Baltimore, Maryland 21215-0036 of Health a Blanche Dulaney 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State Department of Important: If it any injury or conce. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: he law requires that the death certificate be executed burial-tran attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No cate has been signed by the pige 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Be Completed 25. Was case referred to medical examiner? funeral director, 1∐ Yes Certification: To 27. Manner of Death After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;

completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 27188

29d. Date signed (Month, Day, Year)

arker Place Dundale MO 2/222

31. Date filed (Month, Day,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

Registrar

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State

NONTHWEST

31. Date filed (Month, Day, Year)

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MD 21133

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		Please  1 - For State Registrar	State of Maryland	d / Depa		lealth and Me Death	ental Hygie		14537
Physic /Med		Decedent's Name (First, Middle, Las	AUDREY ELAINE 1	ENGLAND	)		2. Date of Death Month May 3, 20		8:18 A M
Exam		4a. Fecility Name (If not institution, give Bonnie Blink Masoni			4b. City, Town, o Cockeys	r Location of Death		4c. County of De Baltimor	
Funera Directo		214-10-3023	7. Age ( <i>In yrs. le</i> ☐ M 2☑ F 86	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, YAug. 25, 1	(ear) 1922 N	Birthplace (State or Foreign Country) ary Land
Maryland -1 show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor		, Town or Lo		sville			10d. Inside City Limits 1 Tyes 2X No
with the 3e or 28e	i Direc	10e. Street and Number 201 Mc	Henry Avenue		10f. Zip Code	21208	100	g. Citizen of What USA	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-1 show eny injury or other treumatic event, Ite Neuloul Exercise Arminist by Invitited at mones.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☼ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	rify Yes or No- ican, etc.)	14. Race - Ar Black, W Specify:	nerican Indian, hite, etc. White
"natura	ieted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of working		6b. Kind of Busine: William &	
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Id be file lental Hy ked oth	To Be (	17. Father's Name (First, Middle, Last)	George Reichert			18. Mother's Name Emma M	(First, Middle, Ma • Seidling		
od 2 shoulth and N		19a. Informant's Name/Relationship (1 Robert W. England	Type, Print) (Son)	19b. Maili 201	ng Address <i>(Street</i> McHenry Ave	and Number or Rural nue, Pikesvi	Route Number, ( 11e, Mary1	City or Town, State Land 21208	a, Zip Code)
in the and the		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆	Removal from State	emetery, cre	osition (Name of matory or other plan be Memorial			oc. Location - City 1kridge, Ma	
permit. Pa Departmer Importent eny injury	i k	`4 □Donation 5 □Other (Specify  21. Signature of Funeral Service Licen	<i>''</i>	2	2. Name and Addre	ss of Facility McCu	IIv-Folyn	iak Funeral	Horre, P.A.
Physiciar /Medica Examiner		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each line.  a	asa	ter the mode of dyir	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death Muntlo
ate be executed thysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate ease. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.				-		
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	dəlivery Day Year
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VILC /sicien s certifi director	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ♥ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Ott	26. Place of Death		nce 6 Other (S	ipecify)
ling Ph		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ry at 2 rk? ] Yes 2 □ No	8d. Describe hov	w injury occurred	
To the Hospitel or Attending Fwithin 24 hours after death. To the Funerel Director: After completely filled in by the funer	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, st		1	8f. Location (Stre City or Town,		Rural Route Number,
a Hospite 24 hours a Funere etely fille	edical C		ysician: To the best of my knowniner: On the basis of examinat and manner stated.						
To the within To the	Me	29b. Signature and title of certifier	est		29c. Licens	se number	29	d. Date signed (M	onth, Day, Year)
(O v		30. Name and address of person who	completed cause of death (Item	23a) (Type	, Print)	Bult	and :	21220	
S	tate	31. Date filed (Month Day Year)	2. Registrar's Signa	ture	del	/	•		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per Phy G891 5/06/09 JH
State of Maryland / Department of Health and Mental Hygiene 1- State Amend # 7,8, & 18 per Fh g891 Eertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 2, 2009 **Physician** William E. Fitch 11:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 1914 1913 8. Date of Birth April 25 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 212-01-5184 1 **X** X M 2 □ F 95 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XX Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1138 Greenway Road 21030 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (1) Alo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No. Specify: Maryland 21215-0036 Specify: ģ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Industrial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Emma McLean Emma McLane Thomas E. Fitch ဂ္ 19a. Informant's Name/Relationship (Type. Print)
Lori Fitch (GrandDaughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1138 Greenway Road Cockeysville, MD 21093 Baltimore, . Method of Disposition

★Method of Disposition

3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5/8/09 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley MG 21. Signature of Funeral Service 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 West Padonia Road Timonium, MD 21093 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ongestive disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical the Se IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached i ☐Yes 2☐No 9☐Unknown 9 Unknown ģ signed b Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ hronic 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy nerforme certificate 1 Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) \( \frac{6 \text{N}}{2} \text{Residence} \) \( 6 \text{ \text{N}} \text{ther (Specify)} \text{Hospice} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this After thi funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division or Attending Injury 1 Natural 5 Pending investigation tal April 17, 2009 unking w V M 28 . Place of injury - At home, farm, street, fa 1 ☐ Yes 2 XNo within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281 Location (Street and Number or Rural Route Number, City or Town, State) (138 Green way determined 4 Homicide Home To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 0 Medical (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M () 110 o trimb 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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2009

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Herbert John Feick Month Year 201219 **Physician** MAY 8:15P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Center Towson Joseph Medical Saint | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb 16, 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 213-16-3102 7. Age (In yrs. last birthday) **Funeral** 87 XXXI 2□ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a 4 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 💢 Director MD Kent Chestertown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 406 Heron Point 21620 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever în U.S. Armed Forces? 11. Marital Status 1 XXes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 1 □ Yes 2 XXIO Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) C&P Telephone Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Herbert Feick Katherine Pfeifer ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Doris Feick (Wife) 406 Heron Point Chestertown, MD 21620 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 12 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/8/2009 Bosley Cemetery Sparks, MD 21. Signature of Funeral Service Ke 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley 10 West Padonia Road Timonium, MD ? 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INFARCTION MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ISCHEMIC CARDIOMYOPATHY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the burla Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown RESPIRATORY FAILURE Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 2 Accident 5 Pending investigation nours after death.
neral Director: All y filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho

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completely f 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 7601 DRIVE TOWSON 31. Date filed (Month, Day, OSLER TABASSI M. D. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, 14540 State of Maryland / Department of Health and Mental Hygien 👂 🖺 🖺 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 12:55 2009 03T. Fisher May James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oak Crest Parkville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral 1** M 2 □ F 215-12-3347 87 Director June 25, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2√ No Director Md. Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 8820 Walther Blvd. 21234 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Be Completed by White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medica 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry t. Pages 1 and 2 should be filed within thent of Health and Mental Hygiene. Tant; if Item 27 Is marked other than lury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Personnel Recruter Employment Agencies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Fisher Margaret Tighe ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important; If Item 27
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once. Mr. Stephen Fisher/ Son 20 Silver Stirrup Ct. Timonium, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-8-09 Prospect Hill Cem. Towson, Md. 21. Signature of Fyneral Service Acenses 22 Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 complicall insithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inly one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONFESTIVE HEART FAILURE END STAGE **Physician** 6 m 05 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was and autopsy performed? Yes 22 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier CRNT R043580 Theis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUSTINE Preis CRN 8832 Wett Worther BIW. Bolto. MD 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

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09-03559 Patricia Finan

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day **Physician** MAY 10:37 P JOSEPH P. GRANT 2, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE PARKVILLE GENESIS CROMWELL NURSING CENTER If Under 1 Year | If Under 24 H Birthplace (State or Foreign-Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours **1** M 2□ F MARYT, AND Director 215-12-2730 3/7/1921 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, The Macical Examinating to notified at 1 ☐ Yes 2 No Director PARKVILLE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 3520 HISS AVENUE death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after on the file of Health and Mental Hygiene. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ WHITE 3 Vidowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) if Health and Mental Hygiene. Item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) CROWN CORK & SEAL PLANT MANAGER 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNAVATLABLE UNAVAILABLE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21234 BALTIMORE, MD 3520 HISS AVENUE HELEN M. WILLE/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition permit. Pages Department of Important: If It any Injury or o XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5/6/2009 BALTIMORE, MD PARKWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MO1139 8521 LOCH RAVEN BLVD. TOWSON, MD 23a Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or all Examiner saturnia y list can ations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a conse P.O. Box 68760. Physician/Medical the as attending IF FEMALE: use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy for Month Day Year 5 Other (specify) □Yes 2□No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 2 No 3 Probably 4 Unknown 1 ☐ Yes cate has been signated by page 2 should by Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 440 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9-03295		Please Ty	oe or Print i	n Black Ir	ndelible l	nk. En	sure	All Co	pies	Are Leg	gible.	,	
rank Leroy Giddi	_	St	ate of Maryla	and / Depa	artment c	f Health	and					20	09 1454
	F	- For State Registrar		Ce	rtificate o	f Death			12	Re 2. Date of Deat	g. No.	20	3. Time of Death
Physiciar Medical Examin	1,0	1. Decedent's Name (First, Midd Frank Lero		nas					1-	Month April 24, 2	Day	Year	1300 hrs
		4a. Facility Name (if not institution	-4			4b. City, To	wn, or Lo	ocation of			4c.	County of Dea	ith
		9045 Dumhart Road				Laurel						oward	(0)
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under Months		If Under Hours	24Hrs. Min.	1		Fore	sirthplace (State or eign Maryland country)
Director	-	217-40-8629 Usual Residence of Decedent	1X M 2 F	(	54 Yr	S.				Jan. 1	19,	1945	
any	-	10a. State 10b. County		10c. City	, Town or Loca	ation							10d. Inside City Limits
Maryland 28a-f show	٦	MD Howa	ard		Lau	rel							1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number				10f. Zip (				1	0g. Citiz	en of What Co	
ith the		9045 Dumhart		cedent Ever in U	IS 13 W	as Deceder		20723		edify Yes or No	- 1	USA 14. Race - Am	A erican Indian, Black,
death w	Funeral	1 Never Married 2 X M				Yes, specify					1	White, etc.	
after d	잘.	3 Widowed 4 Dir	vorced If Yes, Give Ye		1								White
hours natur:		15. Decedent's Education (Spe	ecify only highest gra		16a. Decede during	ent's Usual C most of work					16b. K	ind of Busines	s/Industry
36 111n 72 11 than "	bjet	Elementary/Secondary (0-12) 9th	Ø	1-4 or 5+)	Gen	eral (	ont:	racto	ır			Self En	nployed
5-0036 led within 72 Hygiene. other than	Completed	17. Father's Name (First, Middle								First, Middle, I			projec
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene, nnt: If item 27 is marked other than "natural", or items 23a or 28a-f shour other traumatic event, the Medis all Examiner must be notified at once	8	Ernest Giddi								eth J.			
MD 2: nd 2 should lith and M m 27 is m: aumatic e	P P	19a. Informant's Name/Relations Christine Viol		Personal		•	`					ty or Town, Sta	
and 2 lealth item 2 traun	ŀ	20a. Method of Disposition		20b	Place of Disp	osition (Nam			ROad	d, Lau Date			20723 or Town, State
nore		1 X Burial 2 Crematio			crematory or cestlaw		Gar	cdens	5/1	1/2009	Mai	rriotts	sville, MD
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within. Department of Health and Mental Hygiene. Important: If frem 27 is marked other that injury or other traumatic event, the Media.	t	4 Donation 5 Other S 21 Signature of Funeral Service	Licensee	1		Name and					_		Home, P.A.
	1	Janece	41/XX	WM011		313 7	albo	ott A	veni	ue, La	ure:	l, MD	20707 Approximate Interval
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cuted and transit	Examiner	events resulting in death) Last		a consequence	of):								
and	ᇛᅡ	X UNPENDED	dAMENDED	PI line	e a-b,	27, p	er Mi	E g89	1 5	/7/09 3	ГТ		
tox 68760, leath certificate be ex e attending physician for use as the burial	Physician/Medic	IF FEMALE:	23c. If yes	, outcome of pre								d. Date of deliv	
687 certific	ian/	23b. Was decedent pregnant in past 12 months?	1	birth nant at time of o	1 4 h	etal death Other (Spec	3	Ectopic	pregnar	ncy	!	Month	Day Year
Box re death the atte	ysic	1 Yes 2 No 9 Ur	keoum	nown	31	other (Spec	y/						
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be as ther death.  "In Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the bur		Part II. Other significant cond	tions contributing	to death but not	resulting in the	underlying	cause gi	ven in Par	rt I.				to the cause of death?  Probably 4 Unknown
S, P quires 1 en sign	Completed by									24a. Was			autopsy findings available
cord	ple							_		auto			to completion of cause of
Rec		05. W	I				6 Diago	of Death (	Chack	1 Yes	2N	lo 1 🗸	Yes 2 No
/ital	o Be	25. Was case referred to medic examiner?  1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie			Other <sub>4</sub>		g Home 5	Reside	ence 6 🗸 O	ther: Scene
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.		27. Manner of Death	28a. Dat	e of Injury th, Day,Year)	28b. Time o	f Injury 2	8c. Injury	y at Work	?	28d. Describe	how inju	ury occurred	
ion ttendii death.	atio		nding estigation	,,			1Y	es 2					
livisior of or Attence after death Director:	ıţį:	3 Suicide 6 Cor	uld not be 28e. Pla	ace of Injury - At	home, farm, st	reet, factory,	office bu	uilding, etc	C.	28f. Location or Town,		and Number or	Rural Route Number, City
lospita Hours unera	<u>8</u>	29a. Certifier	Physician: To the b		adae death on	curred at the	time dat	te and pla	ice, and	due to the cau	ıse(s) ar	nd manner as s	stated.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate!	Medical Certification:	(Check only one) 2 Medical Ex	aminer: On the basi	s of examination	and/or investig	gation, in my	opinion,	death oc	curred at	t the time, date	and pla	ace, and due t	o the cause(s)
7.4 E 2 E 8	Me	29b. Signature and title of certif				290		number			1		(Month, Day.Year)
							0.C.N	И.E.			Apr	il 25, 2009 	
OCME		30. Name and address of person Mary G. Ryppie MD.	n who completed ca Deputy Chief			11 Penn	Street.	Baltim	ore, M	D 21201			
Sta	ate	31 Date filed (Month, Day Year	) 32	Registrar's Signa		ale				-			
Registr	_	MAYOF	: 701114 1 ZZ	new	14. 14.	- 10							

			Please T	ype or Print State of Mai				-		ible.	
			For State Registrar	State of Mai		ertificate of			eg. No. 2	09	14544
	Physicia	an	1. Decedent's Name (First, Middle, Last)	RUIH L.	GLAESER			2. Date of Death Month May 5,		Year	3. Time of Death 5:55 A M
	/Medic Examin		4a. Facility Name (If not institution, give s Glen Burnie Health &			4b. City, Town, o	r Location of Death		4c. County	y of Death <b>Arund</b> e	
	Funeral Director		Social Security Number     6. Sex	7. Age	(In yrs. last birthday, 94 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Day, Oct. 25,	Ť914	9. Birthp Cour, Mary	place (State or Foreign stry) Land
Ъ			Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation				1	0d. Inside City Limits
e Maryl	Ba-f sho	ctor	Maryland Anne Arund	리			asadena				1 ☐ Yes 2 📉 No
h with th	23a or 2 st band	al Dire	10e. Street and Number 199 Corr	nfield Road		10f. Zip Code	2112	2	og. Citizen of USA		itry?
JSO Irs after deat	ll", or items ? Describer tou	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ev Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☑ No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ce - Americ ck, White, fy: Whi	etc.
aryianiq zizio-ouso should be filed within 72 hours after death with the Maryland	Department of Health and whorten Inglene. Impartment of Health and whorten Health and 23a or 28a-f show any Injury or other traumatic event, the Modeal Examiner Health once. Once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	edent's Usual Occup e kind of work done DO NOT use retire lonemaker	oation during most of work d)	king	16b. Kind of B Housewii		1
vild be filed	Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last)	Henry H.	Freeman		18. Mother's Nam Ida Her	ne (First, Middle, N	1aiden Surnai	me)	
Mar)	27 is ma r trauma		19a. Informant's Name/Relationship (Ty) Rose M. Parks (I	e. Print) Caughter)	19b. Mail 7789	ing Address <i>(Str</i> ee <i>t</i> Oox Point	and Number or Ru Court, Balt	ral Route Number, cimore, Mar	City or Town	n, State, Zip 21226	Code)
Dalumore, permit. Pages 1 ar	nt: If item		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Disp cemetery, cre Bayview Ci	osition (Name of ematory or other placement ory, Ir	oc. 5/6/0		20c. Location		
permit.	Importa any Inju		21 Signature of Fundral Service License	e Kevin E E	cker 2	22. Name and Addre 3204 Mounta	ess of Facility McCain Rd., Pas	Cully-Polyr Sadena, Md.	niak Fun 2112	eral Ho 2	ome, P.A.
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ecords, r.	n signed b	þ	Part II. Other significant conditions con	tributing to death but	t not resulting in the	underlying cause giv	ven in Part I.				he cause of death? bably 4 🔀 Unknown
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On OI	in. : After this certificate h. s funeral director, page		27. Manner of Death  1 Manuer of Death  1 Manuer of Death  1 Manuer of Death  5 Pending investigation	28a. Date of Injury (Month, Day)	28b. Time	of 28c. Inju Wor	ry at	28d. Describe ho			77
DIVIS	I Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, s (Specify)	treet, factory, office		28f. Location (St City or Town		nber or Rur	al Route Number,
e Hospit	within 24 hours after deau To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1	sician: To the best o ner: On the basis of and manner stat	examination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and i late and place	manner as e, and due l	stated. to the cause(s)
To th	To the company of the	M	29b. Signature and title of certifier  Mochany	NA		29c. Licen			9d. Date sign		
(0	$\checkmark$		30. Name and address of person who co		ath (Item 23a) (Type	e, Print) 3 25	40521 HOSAT GUEN	CAL DR	WE N	fur-	ce 208
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature		9		*		
	17 Pov 1/9	004	THE WEST	1	111						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🛭 🧎 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2009 Day 1:47 PM **Physician** mai George E. Goddard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** AnneArunde Glen Burnie Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs 8. Date of Birth March Day Year 1922 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Maryland Months Days Hours 1 M 2 □ F 87 212-18-9653 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Evanings south the nutified at 1 ☐ Yes 2 No Pasadena Anne Arundel Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. any Ingrorant if item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event. U.S.A. 21122 114 Carroll Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 📕 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Corp. Outside Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Sauers Daniel K. Goddard ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 114 Carroll Road, Pasadena, Maryland (Wife) Gladys D. Goddard 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland 05-07-09 Glen Haven Mem. Park 4 Donation 5 Dother (Specify) 22. Name and Address of Facility McCully—Polymiak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Fuperal Service License 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Imme fate Cause (Final 6 day ere pro-vascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 X No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28a. 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide DECERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

NOVACIC

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

29c. License number

Glen Burnie, MD 21061

29d. Date signed (Month, Day, Year)

and manner stated.

Hospital

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 14546

		- For State legistrar		-	Cert	ificate of	Death		_	Re	g. No				
Physicial	1/	Decedent's Name (First, Midd	le,Last)							Date of Death Month	Day Yea		Time of Death 1605 hrs		
Medical Examin		EARLEAN			GRAVI					May 3, 200	9 lac. County (	of Dweth	1000 1115		
)		4a Facility Name (if not institute 3855 Boarrman Road	on, give stre				b. City, Town Baltimore	·					opposition of the contract of		
Funeral Director		5. Social Security Number 209–40–8933	6 Sex		ige (In yrs. las	st birthday) Yrs	Months [	ear If Und		11-06	-1949	Foreign	try) <b>VA</b>		
>		Usual Residence of Decedent			40- 64-7	Town or Locat						10	Od Inside City Limits		
w any		10a State 10b. County				TIMORE						1	Yos 2 No		
daryland 28a-f show 3 at once.	ġ.	10e. Street and Number			DAI		10f. Zip Cod	G.		110	g Citizen of Wi				
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5-0036 led within 72 hours after Hygiene other than "natural"; the Medical Examiner	함	15. Decedent's Education (Spe			ompleted)	16a Deceder					16b Kind of Bu	siness/Ind	ustry		
72 ho	Completed	Elementary/Secondary (0-12)		College (1-4 c	or 5+)	during m	ost of working	ilte. DU NO	T use retired	')					
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D 21 should ! and Mer 7 is mar	의	ALICE CANADA/									AKE, VA				
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nore, MD 2121: ages 1 and 2 should be fil nt of Health and Mental It If litem 27 is marked other traumatic event,			n 3 🔲 I	Removal from	State Cf	rematory or ot	her place)	,.	5/8/				· 01007		
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Physician	$\dashv$	23a Part Enter the disease, o	r complicat	ions that cause	ed the death.				_				Approximate Interval		
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Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer:On	the basis of e	xamination ar	ge, death occu nd/or investiga	rred at the tim tion, in my op	e, date and i	place, and di occurred at t	ue to the caus the time, date	e(s) and manne and place, and	or as stated due to the	t causo(s)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 03<sup>Day</sup> 2009 09:00 ам **Physician** Mary Lee Gill /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) 09/29/1943 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F Baltimore, MD Yrs. 65 Director 214-40-1231 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Experimental benefitled at 1 □Yes 2 □No Director Baltimore Arbutus MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227 1265 Poplar Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", or þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) is marked other than Data Entry/Administration Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental F Be Albert J. Marshall, Sr. Margaret E. Perrell s 1 and 2 should by Health and Menti other traumatic ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 251 Jenny Lane, Stewartstown, Maryland 17363 Kelly Mercer (Niece/Executor) item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 05/07/2009 Elkridge, Maryland Meadowridge Memorial ☐ onation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exam Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) icate has been signed by the ; page 2 should be detached 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopc performed. 2 1/2 No 2 No 1 ☐ Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the i 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) MAY 0 6 2009

30. Name and address

32 Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 12:37 PM 05 Green 2009 Patricia Rosalie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Franklin Square dale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 8, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Hours Year) 1931 1□M XXF 215-28-7898 77 Yrs Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examinar must be notified at Dunda1k 1 ☐Yes 2X No Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or filed within 72 hours after death with 21222 United States 2420 Meadow Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2**XX**Vo Specify: þ Specify: White 3 ₩ Widowed 4 □ Divorced than "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: if item 27 Is marked other the any liqury or other traumatic event, Ins. 1 page. Own Home Homemaker 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret E. Fritsch Harry C. Turner ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24.20 Mondow Road Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) 2420 Meadow Road Dundalk, Maryland (Son) Mr. James Green 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/5/2009 Baltimore, Maryland Oak Lawn Cemetery 5 Other (Specify) 4 □ Donation of un ral Servi 21. Signatur 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the shock, of heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Non Elevation **Physician** Seament /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Imonaru Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 🗆 No certificate 1 ☐ Yes 1 ☐ Yes r this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \bigcap \) Nursing Home \( 5 \bigcap \) Residence \( 6 \bigcap \) Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an

State Registrar 30. Name and address of person who

MAY 0 6 2009

31. Date filed (Month, Day, Year)

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completed cause of death (Item 23a) (Type, Print)

Hu 9000 Franklin

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 May Garvey 5:30 Lucy Ann /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Stella Maris Timonium Baltimore If Under 1 Year | If Under Months Days Hours 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 F Director 213-18-7129 86 May 6. Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinator ust by notified at 1 Yes 2 No Director N/A Md. Baltimore City 10e. Street and Number 10g. Citizen of What Country? within 72 hours after death with 8 Charles Plaza #305 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify Specify. Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ <u>Attorney</u> Law 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If item 27 is marked oth any Injury or other traumatic even Be J. Thomas Garvey Burke Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary W. Light/Sister 1504 Seling Ave. Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) New Cathedral Cemetery 5/7/09 Baltimore, Maryland  $^{\rm 22.\;Name\;and\;Address\;of\;Facility}$  Ruck Towson Funeral Home, Inc. 21. Signature of 1050 York Road Towson, Maryland 21204 r complications that raused the death Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseage r com shock, or heart failure. ist only Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ea week rcinomo /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical that the death certificate attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) the Ö 9 Unknown 9 ☐ Unknown signed by t 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been significate years in page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate l 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number neima 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 2300 DULANEY VALLEY ROAD TIMONIUM, MDERNESTINE WRIGHT, M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

MAY 06 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Calvin /Medical Town, or Location of Death En Burnle 4a. Facility Name (If not institution, give street and number) Examiner VECK Health Anne Marley 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Min. Days **Director** Usual Residence of Decedent death with the Maryland 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Director yarylan 10g. Citizen of What Country? 10e. Street and Number Bridgevie ŏ 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Invalidation is any injury or other traumatic event, the Invalidation is any injury or other traumatic event. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Electrentary/Secondary (0-12) College (1-4or 5+) mek 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknow-ပ 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 Bridgeview 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Se vice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. App ximate Interval Between Onset and Death Immediate Cause (Final Iltoura aediac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4 Pregnant Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 4 Unknown e cucura 1 🗌 Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed this certificate 2 2 No 1 ☐ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 3 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury after death. 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2. and manner stated.

State Registrar

MAY 0 6 2009

Year

29b. Signature an

31. Date filed (Month, Day,

cause of death

29c. License number

29d. Date signęd (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HARRIS Wale 200 /Medical 4c. County of De 4a. Facility Name (If not institution, Location of Death **Examiner** nune Pleter If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Yrs. Date of Birth (Month, Day, **Funeral** Months Hours 1 2 M 2 □ F Days 213-70-Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machall Experiment, and the netitied at once. 1 TYes 2 □ No Director Manland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 ☑ No 3 ☐ Widowed 4 ☐ bivorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Mechanic 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Nelson William Harris 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 📶 🦰 19a. Informant's Name/Relationship (Type. Print) eon Hamis - son 1034 Wedgewood R Baltimore, Marylan Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 DSurial 2 □ Cremation 3 □ Removal from State Graunsville, Mary rownsville Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Salva Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. App ximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ato ce CONCINOMA **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed remother Alcold) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or within 24 hours a To the Funeral I 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print 30. Name an ST. Paul ST 301 NAZARUTN

State Registrar

Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

			For State  State Registrar	of Maryland		rtment of H		d Menta		ne .No.200	9 14552
			Decedent's Name (First, Middle, Last)					2. Date Mon	of Death	Day Yea	3. Time of Death
	Physicia /Medic		C	harles How	ard H	Hoshall		May	04,	2009	3:59 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of D	eath		4c. County of De	eath
			Holy Cross Hospital			Silver If Under 1 Year			- f Diath	Montgom	ery  Birthplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) Yrs.	Months Days		Vin. (Mo	of Birth oth, Day, Yo 19,	ear)	Country) aryland
	Director		179-20-8338 Usual Residence of Decedent	82				Aug	10,	1720	dry rana
	/land low		10a. State 10b. County	10c. City, Te	own or Lo	cation					10d. Inside City Limits
	Many a-fsh	ģ	MD Montgomery	Burto	nsvi	lle					1 ☐ Yes 2 XNo
	or 28	Director	10e. Street and Number			10f. Zip Code			10g	. Citizen of What	Country?
	23a c		14718 Carson Drive			20866				.S.A.	
	within 72 hours after death with the Maryland glene. glene. than "natural", or Items 23a or 28a-f show the Model Examination or Officed at	Funeral	Armed	ecedent Ever in U.S. Forces?	13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin an, Mexican, P	n? (Specify Yes Puerto Rican, e	s or No- etc.)	14. Race - A Black, W	merican Indian, nite, etc.
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes, 3 ☐ Widowed 4 ☐ Divorced Year o	s 2 □ No Give r Dates:		∐Yes 2∏ No	Specify:			Specify:	White
215-0036	hour tural		15. Decedent's Education		6a. Deced	dent's Usual Occup	ation		16	b. Kind of Busine	
515	in 72 n "na n Andio	ompleted	(Specify only highest grade complete	ed) e (1-4or 5+)	(Give life. L	kind of work done o	during most of d)	f working			
	filed within 72 Hygiene. other than "nai ent, In. Mole	ĕ	Elementary/decondary (0-12)		Elec	trical En				4. 14.	hysics Lab
Maryland 2	be filed tal Hygi d other event, II	BeC	17. Father's Name (First, Middle, Last)							iden Surname)	
<u>Xa</u>	Ment Ment arkec	2	Bayard Benton Hoshall					Jane K			
Jar	2 sho and is m raum		19a. Informant's Name/Relationship (Type. Print)			ng Address (Street					e, Zip Code) 1and 20866
ح صُ	es 1 and 2 should be fi of Health and Mental H f item 27 is marked ot r other traumatic ever		Florence L. Hoshall  20a. Method of Disposition	/spouse				Date		c. Location - City	
Baltimore,	Pages nent of hant of hant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	om State		sition (Name of natory or other place		y 9, 0	1	ŕ	Maryland
	permit. Pages Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Midd	20	wn Cemete 2. Name and Addre	es of Facility	To the	100		Maryrand
g	perm Depa Impo any i		21. Signature of Funeral Service Liverisee	M0077	l D	onaldson	Funera	1 Home	, P.A	rvland 2	0707-4389
			23a. Part1. Enter the disease, or complications the shock, or heart tailure. List only one cause of								Approximate Interval Between
-	Physician		Later Occupation (Figure								Onset and Death
*	/Medical		resulting in death)	ronary Art		Disease					15 years
je.	Examiner		Hy	rertension							25 years
Ļ	D +	je L	If now leading to immediate Due	to (or as a consequer	nce of):						
X	ecuted nd transi	Examiner	that initiated events C	perliidemi				<del></del>			25 years
Ö,	oe exe	ığ	resulting in death) Last Due	to (or as a consequer	nce ot):						
8760	death certificate be executed e attending physician and id for use as the burial-transit	dical	d								
9 ×	eath certific attending p for use as t	Physician/Med	IF FEMALE: 23c. If yes,	outcome of pregnanc	·v					23d. Date of	delivery
Box	atten for u	cian	in the past 12 months?	ive birth 2 Fetal de regnant at time of dea	eath 3	Dectopic pregnance Other (specify)	у			Month	Day Year
0	at the de by the tached	ysi	1  Yes 2 No 9 U	nknown		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
٠ <u>٠</u>	The law requires that the ate has been signed by thouge 2 should be detache	by PI	Part II. Other significant conditions contributing t	o death but not resultii	ng in the u	nderlying cause giv	ven in Part I.	23	e. Did toba	cco use contribut	e to the cause of death?
Vital Records,	w requires been sig should by							— J.	1 ☐ Yes	2 <u>X</u> ]No 3[	Probably 4 🗆 Unknown
ပ္တ	law re as bee 2 sho	bet						24	a. Was an autopsy	24b. Wer	e autopsy findings available to completion of cause of
ř	: The law cate has page 2 :	Completed						1 1	performe ∐Yes 2	ed? deat	h? Yes 2 □ No
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			1		f Death (Chec	k only one,	)	
	Attending Physician: If death. ector: After this certifica by the funeral director, p	2	1 ☐ Yes 2 [X]No	☐ Inpatient 2 XEF		III 3 L DOA		-		ice 6 □Other (	Specify)
Ĕ	ding P. h. After funera	ü	1 X Natural 5 ☐ Pending (/	ate of Injury 28 Month, Day, Year)	8b. Time o Injury	Wor	ryat rk? ]Yes 2.⊟No		escribe nov	v injury occurred	
<u>s</u>	ttend death stor:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	ace of Injury - At home	o farm st		ites Z Linc		cation (Stre	et and Number o	r Rural Route Number,
Division of	lor A after Direc d in by	Certification:	4 ☐ Homicide determined b	uilding, etc. (Specify)	c, larri, or	oot, taotory, omoo		Cit	y or Town,	State)	
	Hospital 24 hours a Funeral stely filled		29a. Certifier 1 X Certifying Physician: To	the best of my knowle	edge, deat	th occurred at the t	ime, date and	place, and du	e to the ca	use(s) and mann	er as stated.
2	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in I	Medical	(Check only 2 Medical Examiner: On the one)	ne basis of examinatio manner stated.	n and/or ir	nvestigation, in my	opinion, death	occurred at the	ne time, da	te and place, and	due to the cause(s)
0	To the within 2	Me	29b. Signature and title of certifier			29c. Licens	se number		29	d. Date signed (M	fonth, Day, Year)
			) Carllet			D4	13237			May 5, 2	2009
			30. Name and address of person who completed					1 300	_	1 1	1 00707
			Paul Armstrong, M.D.	14201 Lau 2. Registrar's Signatur		Park Driv	ve, Sui	te 102	, Lau	reı, Mar	ryland 20707
	Sta Registi			2. Registrar's Signatur		<b>A</b> .					
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** 28, 5:08 PM M April Harmon Elizabeth Dorothy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Jan. 17, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Days 1 □ M 2 🛱 F Virginia 228-50-1290 71 Jan. 1938 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exyminer must be notified at 1 Tyes 2 No Director Maryland | Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20781 5805 42nd Avenue Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: Black þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) be filed within tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Work Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia B. Boxley Lloyd H. Freeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health 12119 Golansville Rd., Ruther Glen, VA 22546 Myrtle F. Fortune (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Saint John Baptist 20c. Location - City or Town, State Date 20a. Method of Disposition Pages permit. Pages
Department of
Important: If It
any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodford, VA 4 □ Donation 5 □ Other (Specify) 5/7/09 Church Cemetery
22. Name and Address of Facility 21. Sign ture of Funeral Service Licen ee C.W. Edwards Funeral Home, Inc. un P.O. Box 395, Bowling Green, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Acute Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed Acute Stroke that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Ö 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💥 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s certificate has 2 🗆 No 1 ☐Yes 2 No spital or Attending Physician: Ti hours after death. Ineral Director: After this certificate y filled in by the funeral director, pa 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Nation 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpati Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Division 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral L Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 29, 2009 D65305 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD 20910 Nabila Khan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May Month 200<sup>r</sup>5<sup>ar</sup> **Physician** 2:57pm M Andrew Healey, Sr. Richard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Sykesville Continuum Care 8. Date of Birth (Month, Day, Year) Dec. 22, 1927 Birthplace (State or Foreign Country) 6. Sex 1**X** M 2□ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days MD 81 Director 218-28-6558 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Sykesville Carroll MD Director 10g. Citizen of What Country USA 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. and if item 27 is marked other than "natural", or items 23a or marked other than "natural", or items 23a or any or other traumatic event, In Machael Examiner must be 1 21784 6625 Marvin Avenue Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Yes. Give ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Crater / Shipper Food Packaging 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Lilley George A. Healey ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6625 Marvin Avenue Sykesville, MD 21784 Mrs. Margaret E. Healey (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important; If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 5/7/09 Lake View Mem. Park 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 Haylt MO0764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscienchi Cardiovascycar Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) ed by the a 1 ☐Yes 2 ☐ No 9 ☐ Unknown 9 Unknown signed | 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4-Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2√LNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 142 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital ◆ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road westminister MD 21157 19, Ridge MALTMOOD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year HAWKINS VENUS MELVIA 1009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Howard Columbia (Columbia) Howard County General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 7, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Y 1910 Days Min. Months Hours 1 □ M 2 🖫 F MD 98 219-36-2217 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Marriottsville MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21104 11280 Old Frederick Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ∐Yes 2 📉 No Specify: Specify: Black. 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Cunningham Logan VanLandingham 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Gode)* 21104 19a. Informant's Name/Relationship (Type. Print) Ms. Angela Meadows (Niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Gardens 5/8/2009 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) RAIGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee Buar MO0764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEAEBLOVACOULTA ACCIDENT disease or condition resulting in death) Due to (or as a consequence of): ATHERN SCLEROSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 No 5 Other (specify) 9 I Unknown 9 ☐ Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐Yes 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

attending physician and for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760. Physician/Medical cate has been signed by the page 2 should be detached Division of Vital Records, ģ Completed Physician: Be

**Physician** 

/Medical

Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examine

Certification: To

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting regist be recified at

Baltimore, Maryland 21215-0036

funeral director, After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

25. Was case referred to medical examiner?

3 ☐ Suicide

6 Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

29c. License number

Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5305

1009

Walt Atha, M.D.

5755 Cedar Lane, Columbia, MD 21044

State Registrar

MAY () G GUUY



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of O.O.

		For State Registrar	State of Mar	-	-	ent of F		i Mentai Hy	/giene Reg. No.	2009	14558	)
Physic	ian	1. Decedent's Name (First, Middle, La	,	6000				2. Date of D Month	Day		3. Time of Death	4
/Medi Exami		Vernica 4a. Facility Name (If not institution, giv		tson	4b.	City, Town, o	r Location of De	Apn ath		County of Death		1
LAMIIII		Ellicott City He		b Cente		llicot			Н	oward		
Funeral		5. Social Security Number 6. S	□M 2VIF	In yrs. last birt		nder 1 Year oths Days	If Under 24 H Hours Mi	n. (Month, D	ay, Year)	Cou	place (State or Foreig intry)	ın
Director		578-26-0620 Usual Residence of Decedent		87				March	13,	1924 Vi	rginia	
iryland show	_	10a. State 10b. County	1	0c. City, Town	or Location			-			10d. Inside City Limits	
ne Ma 8a-f s ptified	Director	Maryland Howard	i   1	Dayton							1 □ Yes 2 No	
with the		10e. Street and Number 4940 Ten Oaks Roa	- d		10	f. Zip Code	:			zen of What Cou	intry?	
death ms 23	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was [	21036 ecedent of H		(Specify Yes or Nerto Rican, etc.)		S.A. 14. Race - Ameri		_
Ind 21215-0036  be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give			specify Cuba es 2X No	an, Mexican, Pu Specify:	erto Rican, etc.)		Black, White		
003 hours ural";	d by	3 Widowed 4 Divorced	Year or Dates:	10-					401 10	Specify: Bla		
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. ?? is marked other than "natural", or traumatic event, the Medical Exami	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)		(Give kind of	Usual Occup of work done OT use retired	during most of w	vorking	7.0	nd of Business/N nce Geor	ndustry 'ge's Count	ΞV
212 d with giene. gr than	lmo:	Elementary/Secondary (0-12) 7	College (1-4or 5+)	Ma	inten	ance				Lic Scho	C	,
Iryland 2 should be filed and Mental Hygi marked other imatic event, ti	Be	17. Father's Name (First, Middle, Last,	)				18. Mother's N	lame (First, Middle	e, Maiden	Surname)		
	2	Samuel Jackson		1				e Tyler				_
re, Maryls s 1 and 2 should f Heath and Mer item 27 is marke		19a. Informant's Name/Relationship (						Rural Route Num.				
lore, M ges 1 and 2 at of Health If item 27 or other tra		Deatrus D. Carper 20a. Method of Disposition		20b Place of	Disposition	(Name of	i	Temple H	20c. Lo	MD 20 / cation - City or T	48 Town, State	_
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item in Injury or othe		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		Mt. H	lope B h Cem	or other place aptist	5/	2/09	Staf	fford Co	VA	
Baltimo permit. Pag Department Important: It any Injury o		21. Signature Funeral Service Licer	see		22. Nan	ne and Addre	ss of Facility	n <u>F</u> unera	1 Hon	ne Inc	• • • • • • • • • • • • • • • • • • • •	П
m goras		June 1	rend	20	200	Butter	nut Dr.	, Freder	ickst	ourg, VA	22408	_
	(	23a. Part1. Enter the disease, or com shock, of heart failure. List only	plications that caused th one cause on each line.	e death. Do n	ot enter the	mode of dyir	ng, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to for an a	HIM	07510	2014	e (ch	dwyuse	al a	5.5.1		
Examiner-			Due to (or as a c	Sem	le d	erre	nlis	dwvas	DU	nene		
₽ .≝	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c									
760, be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a c	consequence of	·f)·							
68760, ficate be ex physician is the burial			Jue to (or as a c	onsequence o	,,,.							
68/ ficate	edical		d								-	
BOX leath certi	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1 ☐ Live birth 2	pregnancy □ Fetal death	3 □Ecto	oic pregnancy	V			23d. Date of deli	,	
at the deg by the at	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	me of death	5 🗌 Othe	er (specify) _				Month	Day Year	
<u> </u>		Part II. Other significant conditions	ontributing to death but i	not resulting in	the underly	ing cause giv	en in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?	
COrdS, w requires s been sign should be	ed by							1	] Yes 2[	□ No 3 □ Pro	obably 4 Unknow	'n
<b>1eCO</b> le law re has bee	plet							24a. Wa	s an opsy		topsy findings availabl	
The tage	Completed							per 1□ Yes	formed?	death?	ompletion of cause of 2 □ No	
VItal Kecords, slcian: The law requires to certificate has been signe rector, page 2 should be contracted.	æ	25. Was case referred to medical examiner?	Hospital:			Oth		eath (Check only	one)			_
Or Phys r this ral dir	٠ <u>.</u>	1 Yes 2 No 27, Manner of Death	1 ☐ Inpatient	2 ER/Out		DOA Oth	Nursing	Home 5 Res			ify)	_
VISION OF VITA Attending Physician: r death. ector: After this certific by the funeral director,	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y		njury N	Wor	k? Yes 2 ☐ No	Zod. Describe	now injur	y occurred		
LIVISION I or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury building, etc.	- At home, far (Specify)	m, street, fa	actory, office			(Street an		ral Route Number,	_
Hospital or 44 hours after Funeral Directly filled in b	Cer											
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier Check only one)  Check only 2 Medical Example 1	nysician: To the best of a niner: On the basis of ea and manner state	xamination and	, death occi d/or investig	irred at the til ation, in my o	me, date and pla opinion, death o	ace, and due to th ccurred at the time	e cause(s) e, date and	and manner as d place, and due	stated. to the cause(s)	
To the Compter	Med	29b. Signature and title of certifier	and manner state	<u>.                                    </u>		29c. Licens	e number		29d. Dat	te signed (Month	i, Day, Year)	_
- 250		5	Ninu			D3	0641		A	pinf ?	27 2009	1
٠		30. Name and address of person who		th (Item 23a) (	Type, Print)	Deel-	A.ve	meda P	and d	12.1h	27 2009 mne May 2122	ly
		31. Date filed (Month, Day, Year)	apalky 32. Registrar's	Signature	109	DUCK	HUEN (	1 10 W 14	020	pull	2122	-
Sta Regista			200	s Signature	ha	Led .					466	
DHMH 17 Rev 1/2	001	MAY 062	UUY Cenn	U p.	Mari							_

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Jones Doris 11:05a 05 2009 03 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Levindale Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2X F 212-34-8420 Director 71 37 MD 09 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show ral", or items 23a or 28a-f shov Examiner must be notified at Baltimore 1 Yes 2 No NA MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or; any or other tranmatic event, Its Marches Expirition must be any or other tranmatic event, Its Marches Expirition must be not a second or the property. 21215 U.S.A. 5832 Jonquil Ave by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private House Keeper na 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Parker ပ Henry Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5832 Jonquil Ave, Baltimore, Md 21215 <u> Moses Jones-Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park5/8/2009 Woodlawn, Md King 21. Signature of Funeral Service Licersee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pullere disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed in boten physician and the burial-tran Due to (or as a consequence of) P.O. Box 68760; Physician/Medical attending p IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) signed by the a d be detached f Tyes 2 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Death 1 ☑ Natural 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation I Director: A d in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide n 24 hours af ie Funerat Di stetely filled in t 🖵 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number +31615 Bultimore, mo ones 30. Name and address of person who completed cause of death (Item 23a) (Type, Print∦ DO 15 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 06 2009 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 14558

		For State		-	Certifica	ate of l	Death					Reg. No.		3	Time of Death
`hysicia		gistrar Decedent's Name (First, Midd								Date of De Month April 29,	Day	Year	3.	1540 hrs	
Mec Examir	ner	Theresa Jac	obs			14	b. City, To	wn orlo	ocation of		April 29,	2009 4c	. County of	Death	
	4	a. Facility Name (if not instituti		nd number)		140	Baltimo		,000.017.01					N/A	
		1703 Wilkens Avenu		7 400	(In yrs. last bir	thday)	If Under		If Under	24Hrs.	8. Date of E	irth (MM	DD/YYYY)	g. Birthp	olace (State or Foreign
Funeral		Social Security Number 240-94-7573	6. Sex				Months	Days	Hours	Min.	2/10/	53		Coun	NC
Director	1	240-34-7373	1 M 2	<b>ζ</b> F	56	Yrs.					2/10/				
		sual Residence of Decedent  Da. State 10b. County	,	11	I0c. City, Town	or Location	on								0d. Inside City Limits
w any	- [ ]	0a. State 10b. County  MD N/A		1	Balt									- 1	1 X Yes 2 No
f sho	호						10f. Zip (	Code					izen of Wh	at Count	ry?
Mary Mary	Director	0e. Street and Number 1703 Wilkens	s Ave				21	223				Ü	SA		
death with the Maryland or items 23a or 28a-f show must be notified at once.				as Decedent B	ever in U.S.	13. Wa	s Deceder	nt of Hisp	anic Origi	n? ( Spe	cify Yes or	No-		- Americ e, etc.	an Indian, Black,
th wi	Funeral	Marital Status     Never Married 2	Married Ar	med Forces?		If Y	es, specify	Cuban,	Mexican,	Puerto R	lican, etc.)			fri	can
er dea	ᇍ		Divorced of Yes, G		X No		Yes 2								ican
rs afte ural"	<u>a</u>	15. Decedent's Education (S	or Date	s'	pleted) 16a	. Deceden	nt's Usual ( lost of worl	Occupation	on (Give k	ind of wo	ork done	16b.	Kind of Bu	usiness/In	dustry
2 hou "nat	황	Elementary/Secondary (0-1		llege (1-4 or 5			aret				,	N	Jursi	ing	
36 hin 7. thau thau	ם	10					arec			- 11	(First, Midd	o Maide	n Surname	9)	
5-00 ed wit tygien other	Completed	17. Father's Name (First, Midd							odes. Odes	sname	Dard	en	, Carris	-,	
21215-0036 said be filed within 7 Mental Hygiene marked other thau c event, the Medica	BB	John Steph	enson,	Sr.		ICH Meilin	a Address						City or To	wn, State	, Zip Code)
21 nould nd Me is ma	입	19a. Informant's Name/Relation	onship (Type, Pr	<sup>int)</sup> uahte:		1107	Cou	rtn	ey R	d, B	alt.	, MD	212.	21	
MD id 2 sho lith and m 27 is		20a. Method of Disposition			20b. Plac	e of Dispo	sition (Nar	ne of cer			Date	20	c. Location	- City or	Town, State
re, slan fHea ff Hea ff itel		1 X Burial 2 Crema	tion 3 Rer	noval from Sta	ate crem	natory or of	ther place	)		5/7	/09	1	Balt	.,MD	)
Page Page nent c		4 Donation & Other	Specify:		Mt.	Zion	Nama and	Address	s of Facilit	V	. D		200	E C	DΛ
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Morelad Hygiera I lin protrant: If item 21s and Morela other than "natural", or items 23a or 28a-f sho injury or other trannantie event, the Medical Examiner must be notified at once.		21. Signature of Funeral Serv	ice Licensee			5	126	Rol	air	'наг Rd.	n P. Balt	. MI	D 21	206-	P.A. 5105
E 5 6 E 1.		23a. Part I. Enter the disease	as complication	e that caused	the death. Do	not enter	the mode	of dying,	, such as o	cardiac o	r respirator	y arrest,	shock, or h	eart	Approximate Interval Between Onset and
siciar Medica,		failure. List only one car													Death
Examine		Immediate Cause (Final dise or condition resulting in deat	ase a. Co	caine (or as a cons	and etl	nanoı	LIIL	DVIC	ation	<u>.                                    </u>					
			b.												
	e l	Sequentially list conditions, if any, leading to immediate		(or as a cons	sequence of):										
	Examine	cause. Enter Underlying Ca (Disease or injury that initiate	ed C.	(or as a cons	sequence of):										
ed ed	EX3	events resulting in death) La	d.						001	- 1- 1	00 mm				
760, icate be executed physician and the burial attacks.	g	X UNPENDED	X AMI	ENDED 23	8a,27,2 8 <b>b,p</b> erM	8a-f	perM <b>91</b> 5/	E 5/6	891 <b>T</b> T	)///	09 11				
so, te be a	Medical	IF FEMALE:	23	c. If yes, outco	ome of pregna	ncv							23d. Date Month		ry Day Year
Box 68760, a death certificate be the attending physical control of the attending physical control of the burners of the burne	1	23b. Was decedent pregnant past 12 months?	in the	Live birth		2	Fetal deat	h 3	Ecto	pic pregn	ancy		I WOTA		,
Sox 687 leath certific	sicie	1 Yes 2 No 9	Unknown 9	Unknown	at time of deat	'' 5	Other (Sp	еспу)	-						
BO BO	3 I E	Part II. Other significant co			ath but not res	ulting in th	e underlyi	ng cause	given in	Part I.					to the cause of death?
P.O.	₹ .	Tart ii. Other Signmount									. 1	Yes			obably 4 Unknown
S, F quires en sig	ompleted										24a.	Was an		1b. Were prior t	autopsy findings availab o completion of cause o
ord aw rec											1	perform Yes 2	ed?	death	
<b>Rec</b> The la	Con							26 Pla	ace of Dea	th (Chec	k only one)				
iam: certifi	ector,	25. Was case referred to m examiner?	edical Hospi	tal:	tiont 2 F	ER/Outpati	ient 3	DOA	Other:		sing Home	5 R	esidence	6 🗸 Ot	her: Scene
Division of Vital Records, P.O. Box 68760, first or Attending Physician: The law requires that the death certificate be executed urs after that the death certificate be executed and Prector: After this certificate has been signed by the attending physician and all prectors: After this certificate has been signed by the attending physician and	funeral director, page	1 <b>✓</b> Yes 2 No	)	28a. Date of I		28b. Time			njury at W	ork?	28d. De	scribe ho	w injury o	curred	
n of	funer	27. Manner of Death  1 Natural 5	Pending	(Month, Da	ıy,Year)	3	3: <b>0</b> 0	pm <sup>1</sup>	Yes 2	X No	unk				
ViSIOF or Attend after death Director:	y the	2 Accident	Investigation	Fd 4/	29/2009 f Injury - At ho	me, farm, s	street, fact		e building	, etc.	28f. Loc	ation (St	reet and N	umber or	Rural Route Number, C
ivis Por A after Dire	filled in by the fune	3 Suicide 6 X	Could not be determined	(Specify)	hous	se					Balt	imo	re, M	D Wi	Rural Route Number, C 1kens Ave
To the Hopital within 24 hours a To the Funeral I					f my knowledg	e, death o	ccurred at	the time	, date and	place, a		no cause	(s) and ma	anner as	stated.
D 12 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	pletel	(Check only 1 Certify one) 2 Medica	al Examiner: On	the basis of e	examination ar	nd/or inves	tigation, in	my opir	nion, death	occurre	d at the tim	e, date a			
To th	completel	29b. Signature and title of	االه	manner state	ed			29c. Lic	ense num	ber			290. Date	signed	(Monan, Day)
	2	Our S	>					Ο.	C.M.E.				April 3	0, 2009	) 
		30. Name and address of	noreon who com	nleted cause	of death (Item	23a)									
		30. Name and address of a	nerson who com Assistant 1	Medical Ex	kaminer	111 Per	nn Stree	t, Balt	imore, f	MD 212	201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month William **Physician** Kirby 2009 4:00A May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges County Hosp. Hyattsville Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1<del>√</del> M 2□ F 59 246-80-7315 12/31/1949 NC Director Usual Residence of Decedent be filed within remover that Hygiene, and Hygiene, seed other than "natural", or items 23a or 28a-1 show seed other than "natural", or items 23a or 28a-1 show seed other than "Adhal Examination must be notified at its event, the Medical Examination must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County Hyattsville, MD MD Prince Georges 1 XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3405 Dodge Park Road 20785 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: black Specify: ģ 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile Machinist 12 h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any lijury or other traumatic event once. Be Rosa M. Little Robert N. Kirby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 19a. Informant's Name/Relationship (Type. Print) 3405 Dodge Park Rd #104, Hyattsville MD Karen Kirby / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cremation Service Inc. 5/8/09 Winston, NC 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home, 1501 E. Fort Ave., Baltimore MD 21. Signature of Funeral Service Licensee Victor Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomyonthy **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mahetec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Respondery 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Mann of Death 28b. Time of 28c. Injury at Work? After 1 1 Patural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Algorithms of the funeral py the function of the functi investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cegatier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 2009

WAM BONCE

pa HospHa 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301

Hosp. One Cheedy MD 2078S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #1 Per Phy G892 6/11/09 Department of Health and Mental Hygiene amend 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2Y819 Month MAY Day 12:11 **Physician** MARGARET MARY KUMBUKA Margaret Mary Kambuka /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Saint If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 19, 1952 9. Birthplace *(State or Foreign Country)*Tanzania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 🏝 F none 57 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 21239 6440 Falkirk Road, Apt J Tanzania permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Evantment must once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: Specify: black 3<sup>™</sup> Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fatuma Mkomwa Raphael Mkomwa ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6440 Falkirk Road, Apt.J, Baltimore, MD 21239 19a. Informant's Name/Relationship (Type. Print) Mahadia Kumbuka/ daughter Date 14, 20c. Location - City or Town, State 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) May 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Dar es Salaam, Tanzania 2009 4 ☐ Donation 5 ☐ Other (Specify) Kinondoni Cemetery 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee . Kein Stile 313 Talbott Ave., Laurel, MD 20707 M01053 23a. Fort 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): ADULT RESPIRATORY DISTRESS SYNDROME Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ACQUIRED IMMUNODEFICIENCY SYNDROME the Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last physician a the burial-t Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown PNEUMOCYSTIS PNEUMONIA Were autopsy findings available prior to completion of cause of death? 24a. Was an MYCOBACTERIUM AVIUM SEPSIS autopsy performed? Yes 2 2 No 1 □Yes 1 ☐ Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

D31826

OSLER DRIVE TOWSON MARYLAND 21204

withicum

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD LINTHICUM, M. D.
Date filed (Month, Day, Year) 22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** May 3 2009 1:30 P M Regina E. Kratz /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Keswick Multi Care Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 F Yrs. December 20 1916 Baltimore, Maryland 218 18 6437 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Uves 2 No Director Maryland | Baltimore City Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 700 W. 40th Street 21211 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify. ģ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) N/A Secretary T.K. Sanderson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Fischer Unknown ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Regina A. Kleylein 3101 1/2 Willoughby Road Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 □Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem. May 6 2009 Baltimore, Maryland 22. Name and Address of Fac aure of Funeral Service Licensee Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 to or complications that caused the death. Do not enter the mode of dying, such as cardiac or List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. heavt FAILUVE Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse tience of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☐No 3☐ Probably 4☐Unknown dista 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ₩6 24a. Was an autopsy performe 1∐ Yes 24 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural

Examiner law requires that the death certificate be executed use as the burial-trar and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria been signed by the should be detached page 2 certificate Physician: director, this funeral or Attending within 24 hours after death

To the Funeral Director: A

**Physician** 

/Medical

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5 Pending investigation

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

Elvery

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29c. License number 5102 29d. Date signed (Month, Day, Year)

State Registrar

Medical

Don M.T 31. Date filed (Month, Day, Year)

om mo

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

5901 north CHarles

and manner stated.

6 ☐ Could not be

32. Registrar's Signature

1. Decedent's Name (First, Middle, Last) Month 5RTRUDE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 2503 TANEY ROAD BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 □ M 2 💢 F 89 103-07-3050 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural" --- any injury or other traumatic everal. 10c. City, Town or Location MD N/A BALTIMORE 10f. Zip Code 10e. Street and Number 2503 TANEY ROAD 21209 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) Be LOUIS RITTER ANNA ပ 19a. Informant's Name/Relationship (Type. Print) SHEILA FECHTER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State BETH DAVID CEMETERY 105/05/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Themones disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown signed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> icate has been sig , page 2 should b 1 Tes Completed 24a. Was an autopsy perform certificate I or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) Botho My 2120 Coldbon 31. Date filed (Month, Day, MAY 06 Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 2009 4:25 A 4c. County of Death N/A 8. Date of Birth (Month, Day, Year) 11/24/1919 Birthplace (State or Foreign Country) 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc Specify: WHITE 16b. Kind of Business/Industry OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) JAKOBOWITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6316 IVYMOUNT ROAD, BALTIMORE, MD ELMONT, NY SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 710 yrs 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2X No 1 ☐ Yes 2 🗆 No Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 200 KELLER MELVIN /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner altimore (thuore N/A 9. Birthplace (State or Foreign NEW NEW ORK (In yrs. last birthday) 85 Yrs If Under 1 Year | If Under 24 Hrs 8. Date of Birth 5. Social Security Number **Funeral** Months Ye1924 1 X M 2□ F 264-22-4998 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the finalist Examination to most be mortified at 1 ☐ Yes 2 X No MD BALTIMORE STEVENSON **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10810 LONGACRE LANE 21153 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: WHITE Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Celege (1-4or 5+) MEDICAL PHYSICIAN 18. Mother's Name (First, Middle, Maiden Surname) SARAH 17. Father's Name (First, Middle, Last) IRVING Be ROSEN **KELLER** ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10810 LONGACRE LANE STEVENSON, MD 21153 IRENE KELLER/WIFE Department of Health Important: If Item 27 any Inlury or other tr 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/03/2009 BALTIMORE HEBREW REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature o Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final YPOX ENLO **Physician** Lours disease or condition resulting in death) /Medical Due tylo as a consequence o) Examiner PULLOUIG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last us to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? centributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 3 Probably 4 Unknown 1AYes 2□No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed? 1 □ Yes 2 No Antension 25. Was care regred to medical examiner? 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ÎNo
27. Manner of Death Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A
bletely filled in by the fi 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Goraon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

MAY 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 832 pM Ruth Long Linda 9005 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Square Hospital Center Rosedale Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 26 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. North Carolina 1 □ M 2√2 F 64 216 42 3432 1944 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location rartment of Health and Mental Hygiene. ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, I'm Wedical Exammer must be malled at 10a. State Director 1 □Yes 2 □No Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 1912 Middleborough Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X If Yes, Give Year or Dates: 2**X**] No 1 Never Married 2 Married בסחק לנומל Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygin Important; If Item 27 Is marked other: any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Ruth Scroggs Charlie Lee Rhyne ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1912 Middleborough Road Essex Maryland 21221 19a. Informant's Name/Relationship (Type. Print) (husband) Henry W. Long 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 7, 2009 Baltimore, Maryland Donation 5 ☐ Other (Specify) Oak Lawn Cemetery ure of Funeral Service License 21. Si 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 old eastern Avenue Essex Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1 shoo Imm diate Cause (Final dise se condition result g n death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □No signed by the d 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performe this certificate 2 No 1 ☐ Yes To the Hospital or Attending Physiclan; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral ( 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

DR BINH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nouyen

9000 FRANKLIN SQUARE OR Balto Md

VGUYER

2. Registrar's Sign

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No.-3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year MAY Month 8:14 P **Physician** MARIE LEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗹 F 90 220-30-883 17, Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examination must be notified at 1 Yes 2 □ No MD FREDERICK FREDERICK Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number CATOCTIN AVE 21701 USA 349 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: BLACK þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) JEWGRLEY 2 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALES PERSON STORE 10 Th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANCES AMBUSIT HARRISON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PROSPECT BWD. APT 5-D FREDERICK MD 21701 MARY E. Ltb 501 Health em 27 l DAU) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State RESTITAVEN MEM. GAR MAY 9, 2009 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARY L. ROUNS FUN, HOME 21. Signature of Funeral Service Liounses 21701 X. IN WEST SOUTH ST FREDERICK MO Dun Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final In farction **Physician** Myocardial disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No ed by the detached i 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 ∐Yes 2 No 1 Nation 2 ER/Outpatient 3 DOA မှ 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

ie Hospital or Attending P n 24 hours after death. ie Funeral Director: After t To the I within 2 To the I Complet

> State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 0 6 2009

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Bianca P Udugampola-Stewart 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

400 W 7th St.

29c. License number

MDD67750

29d. Date signed (Month, Day, Year)

05,04,09

Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 200° ΜÄΫ́ 6:51 A **Physician** LISBERGER WALTER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE OWINGS MILLS ATRIUM VILLAGE 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min (Month, Day, Year) 04/09/1915 Months 1 X M 2 □ F **GERMANY** 215-28-3600 Director Usual Residence of Decedent 10d. Inside City Limits e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the precion Examinar must be notified at 1 □Yes 2 No Director BALTIMORE OWINGS MILLS MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21117 USA 4730 ATRIUM COURT Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify Specify: δ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LEATHER GOODS SALESMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fi if Health and Mental H Item 27 is marked ot Be SCHMIDT LISBERGER ROSE MAX ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2895 COUNTRY WOODS COURT, FINKSBURG, MD 21048 BERNARD LISBERGER / SON permit. Pages 1 and Department of Healt Important: If Item 2' any injury or other once. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED | 05/03/2009 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final end-Stolac cardiomyopathi **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached q 🗆 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division of Vital Records, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MSKajafaxneNID

MAY 06 2009

29a. Certifier (Check only

25 Main St., Suite 200, Relsterstown, MD. 21136 N.S. Kajapakse, M.D.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DU057465

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 10:00PM Physician May 2 /Medical y Location of Death 4c. County of Deat 4a, Facility Name (If not institution, give street and number) 4b. City, Town Examiner utureCare Lochean Battimore If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Gountry) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 1 M 2 T 9250 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, Item Medical Evantines at 1 I Yes 2 No Director yanyland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Dac δ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Geoeders of work done during most of working life. DO NOT use retired) Hotel permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Carter Lewis William Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara 20b. Place of Disposition (Name of cemetery, crematory or other place)

William Hope 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10109 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stage **Physician** nd HIZheimer disease or condition resulting in death) /Medical Due to (or as a contequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality (or as a consequence of) Examine be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 00 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2ŽNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After t or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sidnatur 30. Name and address of pe yon who complet duse of death (Item 23a) (Type, Print) ite 200 Rewlerstown, Md 21136 Seay 25 Main Street Dovothy Seay 31. Date filed (Month, Day, Yeak) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene  $\cup$ For Stata Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month 5 Martha 2 **Physician** V. Moats 2009 02:50am /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Future Care Chesapeake Arnold, MD Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 09/16/1922 5. Social Security Number 220 – 18 – 6336 7. Age (In yrs. last birthday) **Funeral** 1 M 201 86 Yrs. WV Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
and: If Item 27 is marked other than "netural; or items 23a or 28a-1 show up; or other traumatic event, Ite Medical Examinational to notified as ury or other traumatic event, Ite Medical Examinational to notified as 1 ☐ Yes 2 No MD Glen Burnie Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 1005 Nancy Road Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 27② No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes **X** XNo Specity: Specify: Baltimore, Maryland 21215-0036 2 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 0 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Elizabeth Moats E. Poling Susan Robert Η. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 Aquahart Rd, Glen Burnie MD 21061 Donald Moats / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 20029. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cross Roads Cem May 6, 2009 Philippi, \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc
1501 E. Fort Ave, Baltimore MD 21230 Censee Victor Doda re of Funeral S Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition + nonotes RESPIRATOR Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 mon 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No \*ttending Physician: 26. Place of Death Check on one 25. Was case referred to medical Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Affer 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide afte To the Hospital or within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

30. Name

31. Date iled (Month, Day, Year) 32. Registrar's Signature MAY 0 6 2009

address of person who completed cause

-INKROMMI

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

P.O.

Perter DenesMD 8600 Old Georgetown Rd, Bethesda MD 20814

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 **Physician** A M April 27, 6:05 Lettie Mannaway /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Arcola Nursing Home & Rehab Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 💢 F Uniontown, PA 92 June 8, 1916 208-24-8387 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Molical Examinar must be notified at 1 Tyres 2 □ No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code Apt. 10e. Street and Number 31513 20902 USA 1131 University Blvd. West Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No
If Yes, Give
Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: à Black 3 Midowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental F item 27 is marked ott Be Gertrude Saunders Major Turpin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1131 University Blvd West Apt. 31513 Silver Spring, 🐠 Shirley Mannaway 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages ' permit. Pages Department of Important; If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 5-2-09 Oaklawn\_Cemetery Uniontown, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lantz Funeral Home 297 E. Main St., Uniontown, PA 15401 Sign Fire of Funeral Service Licensee Approximate Interval Between Onset and Death t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. sh Immed te Cause (Final Physician WHI. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Exami Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, RIVE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2X No Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certifica neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🛛 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, 0 6 2009

29b. Signature and title of certifie

30. Name and address of person 80

Year)

NEME

who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician  $P^{M}$ 2009 1:18 28, April William McCauley Roger /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and pumber) Examiner -linton 6 Soul Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Months Davs Hours 1 X M 2 □ F Washington, Oct. 6, 1939 578-54-6861 69 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2 🕅 No Director Maryland Prince George's Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 U.S.A. 7203 Sunrise Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ Nol 960 If Yes, Give Year or Dates: 1963 14. Race - American Indian Black, White, etc. 11 Marital Status 1 X Never Married 2 ☐ Married Specify: White 1 □Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction 12 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janie Stinson James William McCauley ౖ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7203 Sunrise Dr., Lanham, MD 20706 Janie S. Campbell 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burj → 2 Cremation 3 Removal from State 5/1/09 Gladstone, VA Stinson Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Robinson Funeral Home, Inc.
667 Court St., Appomattox, VA 24522 21. Sign ture of F, neral Service cen Moune Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Disc A-Terios **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2☐No the 9 I Inknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2☐ER/Outpatient 3☐ DOA 1 Inpatient Certification: To After this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manne of Death (Month, Day, Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hin 24 hours after deat the Funeral Director: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300/ 32. Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	aryland		rtment <i>tificate</i>			and Me		giene Reg. No.	Z 11 11	9	14572				
	Physici /Medic		1. Decedent's Name <i>(First, Middle, La</i> Ruth Ann Murra	•						2	2. Date of Dea Month May	ath 2 <sup>Day</sup>	Ž 0°		3. Time of Death 4:00 a M				
	Examir		4a. Facility Name (If not institution, giv Stella Maris Nu				4b. City, T		Location of	f Death			County of De						
	Funeral Director		219-48-0325	Sex 7.Ag □M2⊠F		as <i>t birthday)</i> 51 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birl (Month, Da Nov . 3 ,	h y, <i>Year)</i> 19 <b>4</b> 7	9. B	irthplace Country)	e (State or Foreign MD				
	ne Maryland Ba-f show	Director	Usual Residence of Decedent           10a. State         10b. County           MD         Howard			Town or Lo									Inside City Limits 1 □Yes 2 ☑ No				
	th with the 23a or 2	ral Dir	10e. Street and Number 8255 Savage-Guil	ford Road			10f. Zip	0794	l			USA	izen of What (	ountry:	<i>(</i>				
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, II.s. Froilor Exp., inc. must be notified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 □Yes 2XI If Yes, Give Year or Dates:			Was Decede fYes, speci I∐Yes 2		ispanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	oify Yes or No lican, etc.)	-	14. Race - Ar Black, Wh Specify:						
21215-0036	within 72 ho iene. than "natur ine Medical	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or t	5+)	16a. Deced (Give life. I		k done o e retired	during most i)		9	Ove	ind of Busines rhead hingto	Door	•				
Maryland 2	ould be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last Ashley Posey	)	18. Mother's Name (First, Middle, Maiden Surname) Rachel Joan Grimes  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Si							Surname)							
, Mar	and 2 sho ealth and n 27 is ma	13	19a. Informant's Name/Relationship ( William M. Murra			8255	Savag	e-Gu	ilfor			sup,	MD 20	794					
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau		20a. Method of Disposition  1 ☐ Burial 2 ★ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Conten			ace of Dispo emetery, cren st Aru	ndel	Cren	ı. ¦	May 20	5 <b>,</b> 09	od	enton,	on, MD					
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral  M01053  313 Talbott Ave., Laurel, MD 2070																
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each li	<sup>ne.</sup> 11 Thi	combos		e of dyir	ng, such as	cardiac or	respiratory a	rrest,		In Oi	pproximate terval Between nset and Death .nutes				
68760,	ifficate be executed with the purial-transit and and as the burial-transit and and as the burial-transit and and and a second a second and a second	edical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Metasti Due to (or as  c	c Car	cinom	a							we	eeks				
O. Box	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as I	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ▼ No  9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  1 □ Live birth 2 □ Fetal death 5 □ Other (specify)												ay Year				
rds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resoluting in the underlying cause given in Part I.											cause of death?					
Vital Records,		Completed									24a. Was auto perfo 1 □Yes	psy rmed?	prior death	to comp	y findings available letion of cause of				
<b>Zit</b>		Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	O 🗆 I	ER/Outpatier		Oth	OF!		(Check only o		6 ☐ Other (S						
ion of	tending Physical Appearth.  tor: After this the funeral di	ation: To	27. Manner of Death  1XXNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ury	28b. Time o Injury		8c. Injur Wor	y at	2	8d. Describe			респу)					
Division	l or At after c Direc	Certification:	3 Suicide 6 Could not be determined	building, el	с. (Ѕреспу	′′					City or To	wn, State	9)		Route Number,				
0	To the Hospital within 24 hours a To the Funeral completely filled	edical		hysician: To the best miner: On the basis of and manner st	of examinat														
1	To the within 2 To the comple	Mec	29b. Signature and fittle of certifier	1 /12	llea	un	0	Licens	e number				ate signed (Mo		y, Year)				
			30. Name and address of person who				Print)												

State Registrar

31. Date filed (Month, Day, Year)

MAY 0 6 2009

William A. Warren, MD, 321 Prince George Street, Laurel, MD 20707 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 0252 7009 ale /Medical 4a. Facility Name (If not institution, dive street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner Augsburg Lutheran Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda Baltimore If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Months 1 □ M 2 T F 223-18-0624 93 Director 02 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f show notified at 1 XYes 2 □ No Baltimore MD NA Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number If item 27 is marked other than "natural", or Items 23a or or other traumatic event, the Medical Examiner must be a U.S.A. 21207 7408 Marston Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: þ Black 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wir Department of Health and Mental Hygien. Important: If item 27 is marked other tha any Injury or other transmitted. <u>Nutritionist</u> Specialist Balto.City Schools 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Fowlkes ပ Hiram Fitzgerald 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7408 Marston Road, Baltimore, Md 21207 Debrah Lane-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 5/9/09 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) Kinq 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 力 trun 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lascular **Physician** Pars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes → No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 213 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) al or Attending Plater death. 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗍 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03757 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ZIDel

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Box 68760

Division or Vital Records, P.O.

**ORIGINAL** 

Registrar's Signature

51

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First\_Middle, Last) 3. Time of Death Month 44 PM **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8800 Walther Blvd. 3117 Parkville Baltimore Apt. 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🛛 F Yrs Director 23, 1922 Maryland 87 Jan. <u> 213~16~1124</u> Usual Residence of Decedent the Maryland show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Evantiner must be notified at Director Maryland Baltimore Baltimore County 1 ☐ Yes 2XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21234 USA 8800 Walther Blvd. Apt. 3117 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐Yes 2 No Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White \$ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7, th and Mental Hygiene.
7 Is marked other than "n Flementary/Secondary (0-12) 12 yrs. Bookkeeping Retail Industry 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event ODE. 17. Father's Name (First, Middle, Last) Be Anna Schaefer Joseph Krastel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11324 Cedar Lane Kingsville, Md. 21087 Cathy A. Coggins (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition NXBurial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 5-9-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Lassann Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Peri 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due t (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) the death certificate be executed Exami and burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 🗌 No 3 Probably 4 → Hinkhown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 2 No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral dire Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800

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State Registrar

31. Date filed (Month,

W

32, Registrar's Signature

Purmus !

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year April 27, Lillian Ann Marshall 10:48 AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Dunblane Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5/26/1947 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2**XX**F Maryland 216-46-4277 61 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 No MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Road 1003 Dunblane USA 21286 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married 1 ☐Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cerruti Joseph A. O'Neill Norma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Towson, Maryland 21286 1003 Dunblane Road C.E. Marshall/ Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 5/4/2009 Hilltop Serv. Corp. 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNIOVASCUI OT ue to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PERLIPIDEMIF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed2 Yes 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Division of Vital Records, P.O. Box 68760,

certificate be executed and burial-trar signed by the attending physician certificate has page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Completed

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Certification: To

Medical

29a. Certifier

31. Date filed (Month, Day, Year)

MAY 0 6 2009

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It we Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic event, Item Medical Examinations and Injury or other traumatic events and Injury or other events and Injury or othe

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

29b. Signature and itle of certifier

29c. License number

154 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Park Wr. Ste 285

30. Name and a cross of property of the post of the po

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1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  3. Time of Death			-	State of Maryland		artmen <i>rtificat</i>					iene <sub>g. No</sub> 2 (	009	1 1:	576
School Section Number   Color methods give afreed and number   School Section		Physicia	an	1. Decedent's Name (First, Middle, Last)	Myers					Month	Day Year		-	
Special Section Number   Special Prince   Special Princ				4a. Facility Name (If not institution, give street and number)	etreet and number) 4b. City				of Death	1124	4c. Cou	nty of Death	า	
The property of the property		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under	1 Year	If Under		8. Date of Birth			lace (State	or Foreign
100. Street and Number   100. Street and Num				212-14-2191	Yrs.	WOTHIS	Days	Hours	141111.	10/03/19	21	Baltim	ore, M	)
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20. Method of Disposition   Secure   Se		the Ma 28a-f	recto				Code			1	0g. Citizen	of What Coun		- 24
20. Method of Disposition   Secure   Se		23a or	ral Di											
20. Method of Disposition   Secure   Se	36	s after des ", or items		Armed Forces?  1 ☐ Never Married 2 ☐ Married	1					ecify Yes or No- Rican, etc.)		Black, White, e	etc.	
20. Method of Disposition   Secure   Se	2-00	72 hour natural	eted t	15. Decedent's Education	16a. Dece	dent's Usua kind of wo	al Occup	ation during mo	st of work		16b. Kind o	f Business/Inc	dustry	
20. Method of Disposition   Secure   Se	121	within iene.	omple	Elementary/Secondary (0-12) College (1-4or 5+)				1)			At Ha	me		
20. Method of Disposition   Secure   Se	nd 2	be filed tral Hyg d other event, t		17. Father's Name (First, Middle, Last)						•	Maiden Suri	name)		
20. Method of Disposition   Secure   Se	Iryla	should I nd Men marke Imatic	ဥ		19b. Mailir	ng Address	(Street				; City or To	wn, State, Zip	Code)	
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Physician / Medical Examiner  Physic	$\theta$ Baltir	permit. P Departme Importan any injur			Ê	vans f						es-Par	kville	
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Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that fail inlated events by resulting in death) Last  O CO				ulting in death)	atte	na	0	1		A .				
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Second   S	9 6876	ificate t g physias the b	edica	d				See 1			-			
SACH   STATE	2009 Box	death cert attending for use a	ician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal  4 □ Pregnant at time of december 2.5c. If yes, outcome or pregnant at time of december 2.5c. If yes, outcome or pregnant at time of december 2.5c. If yes, outcome or pregnant at time of december 2.5c. If yes, outcome or pregnant at time of december 2.5c. If yes, outcome or pregnant at time of december 2.5c. If yes, outcome or pregnant at time of december 2.5c. If yes, outcome or pregnant at the past 12 months?	death 3[			у			23d		-	Year
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24a. Was an autopsy performed?   1   Yes   2   No	MAS rds,	quires ti n signe	Ď	Tatti. Other significant conditions continuously to death but not reco						1 □ Y	es 271	lo 3∏ Pro	bably 4	] Unknown
Company   Continue	eco	law rec nas bee	nplete							autop	sv l	prior to co	opsy finding ompletion of	s available cause of
Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)	a 田	ın: The ificate h or, page		25. Was case referred to medical			<del></del>	26 Pia	ce of Dear	1 □ Yes	2 No		2 🗆 No	
27. Manner of Death 1 Manural 5   Pending investigation 3   Suicide 4   Homicide   See. Place of Injury 2   See. Place of Injury 3   See. Place of Injury 4   See. Place of Injury 5   See. Place of Injury 6   See. Place of Injury 6   See. Place of Injury 6   See. Place of Injury 7   See. Place of Injury 6   See. Place of Injury 6   See. Place of Injury 7   See. Place of Injury 8   See. Place of Injury 9   See. Place of Injury 10   See. Place of Injury	RS I	hysicla his cert I directe		examiner?			OA	ner: 4 X	,9	ome 5 Resid	ence 6		ify)	
Second of the control of the contr	MYE on c	iding P. h. After t	tion:	1 Natural 5 Pending (Month, Day, Year)					□No	28d. Describe h	ow injury o	ccurred		
29a. Certifier (Check only one)	ARY ivisi	or Atten fter deat irector: n by the	rtifica	2 DACOIDERT	me, farm, st	reet, factor	y, office			28f. Location (S City or Tow	treet and N n, State)	lumber or Rui	ral Route Nu	ımber,
one) X NURSE PRACTIFICATER	≥ □	ospital of hours a nueral C		29a. Certifier 1 Certifying Physician: To the best of my know	vledge, dea	th occurred	d at the ti	ime, date	and place	, and due to the	cause(s) ar	nd manner as	stated.	e(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		the Hothin 24 the Fu	Medic	one) X NURSE PRACTITIONER										
R149792 5/5/2019		⊨≱⊭ర		1 Stancelano			R14	1970	12		5/3	5/200	9	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JACKIE JONES, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093		10					ת ול 🖯	ודית	MONTTI	M MD 2	1093			
State State Registrar  AV 0.6 2009  State State Registrar				31. Date filed (Month, Day, Year) 32. Registrar's Signat	ure		UAD	<u> </u>	70 TAT O					

MAY 4, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Belinda Ann Morrow 2, May 2009 08:35 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Months Days 1 □ M 2**X** □ F Hours 56 Maryland 213-58-1149 Nov. 10, 1952 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 1 ☐ Yes 2 No Maryland Harford Bel - Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 956 Chesney Lane 21014 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Ye*s* 2**X** No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Unemployed Unemployed 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Florence Weichert Irvin C. Sweeting 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7419 Brookwood Ave. Nottingham, Maryland 21236 Mrs. Holly Maria Mycka (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel

Bel – Air 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/3/2009 Forest Hill, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Peaceful Alternatives Funeral & Cremation Center, P.A. re, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 1 Day a. Chrebral Ebana Due to (or as a consequence of): Intracranial Hemorrhage 2 Day Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f sho

"natural", or

hours after death

within 72 h

12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked of any injury or other traumatic

traumatic event,

Maryland 21215-0036

Baltimore,

Examiner certificate be executed ending physician and use as the burial-transit Box 68760, Physician/Medical attending properties for use as signed by the a P.0. of Vital Records, \$ s been si should b Completed page 2 Physician; Be

sertificate has director, After this funeral death. within 24 hours after death

To the Funeral Director:
completely filled in by the f

23a. Part 1 Enter the disease shock, or healt failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number

3

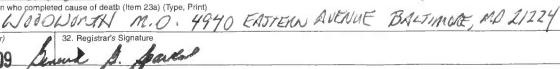
Certification: To

Medical

State Registrar

GRAEME 31. Date filed (Month, Day,

30. Name and address of person



who completed cause of death (Item 23a) (Type, Print)

MAY 0 6 2009

To the Hospital or Attending

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 7:16 PM <sup>M</sup> April 29 2009 Eileen H. Marion 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gilchrist Center for Hospice Care Towson Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days Min. Hours 1 □ M 2 🗷 F Months 10/11/1940 MD 212-36-9240 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1-Yes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 618 S. Montford Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐Yes 2 No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health Care Elementary/Secondary (0-12) College (1-4or 5+) Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Kathryn O'Grady James Holden Hines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60th St. #3R New York, NY 10022 Scott David Buschman/Son 242 E. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Apr 30 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2009 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE WEEKS Due to (or as a consequence of): 2000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 █ No Year Day 5 Other (specify) □Yes 9 Unknown 9 Unknowh 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 **N**O 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

**Physician** /Medical Examiner of Vital Records, P.O. Box 68760, Division

cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran this certificate Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

**Physician** 

**Examiner** 

**Funeral** 

**Director** 

show

Director

Funeral

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Completed

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Completed

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Certification: To

1 Watural

2 Accident

3 Suicide

29a Certifier

4 Homicide

MD

?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic access.

death with the Maryland

Baltimore, Maryland 21215-0036

600E

/Medical

State

the

Medical

Registrar

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) APRIL 30, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

BALTMORE, MD 21204 6565 N CHAPLES ST, SUITE 209 CANIEUE DI BERMAN, MO

31. Date filed (Month, Day, Year)

MAY 06 2009

▲32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Dep  State of Maryland / Dep  Registrar  Ce	artment of Health and N <i>rtificate of Death</i>		.no2009 14579				
O	Physicia	an	1. Decedent's Name (First, Middle, Last)  Gary Mathews		2. Date of Death Month May	Day Year 8:20a M				
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
e de la companya de l	Funeral		9926 Old Court Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Woodstock  If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y	Baltimore  9. Birthplace (State or Foreign Country)				
	Director		212-50-6335	Months Days Hours Min.	April 5,	1947 MD				
	aryland show	'n	10a. State 10b. County 10c. City, Town or L MD Baltimore Woodst			10d. Inside City Limits 1 ☐ Yes 2 1 No				
	th the M or 28a-f	<b>Direct</b>	10e. Street and Number	10f. Zip Code 21163		j. Citizen of What Country?				
	death wi ms 23a	Funeral Director	9926 01d Court Road  11. Marital Status	Was Decedent of Hispanic Origin? (Slif Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.				
36	rs after		1 Never Married 2 Married  3 Widowed 4 Wiovorced  Armed Forces?  1 Y Yes 2 No If Yes, Give Year or Dates:  1969	1 ☐ Yes 2 ☐ You Specify:	Thours, cross	Specify: white				
15-00	"natura	Be Completed by	15 Decedent's Education 16a Dec	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ring I	sb. Kind of Business/Industry eating & Air				
212	ed within ygiene. er than t, If	Comp	Elementary/Secondary (0-12) College (1-4or 5+) tec	chnician		conditioning				
land	Id be file lental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Rolfe Mathews	Dolores Dolores	e (First, Middle, Ma Bahr	iden Surname)				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Medical Examination colling a once.	-		ing Address (Street and Number or Ru River Lane, Trapp						
ore, l	es 1 and 2 : of Health a If item 27 is or other trau		20a. Method of Disposition 20b. Place of Disposition cemetery, or	osition (Name of ematory or other place)	Date 20	Oc. Location - City or Town, State				
Itim Tim	nit. Pag artment ortant: I injury c injury c		4 □ Donation 5 □ Other (Specify)	ty Cremation 5-6-	- 1	ykesville, MD ral Home & Chapel				
B	permi Depar Impor any ir		▶ Saige Haught Sterbert	P.O. Box 195 Sykes	ville, MD	21784				
in.	Physician	(S. II)	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on such line.  Immediate Cause (Final disease or condition	tic Cardiovascu		Interval Between Onset and Death				
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):							
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events the sequence of the conditions of the co							
0,	icate be executed physician and the burial-transit	Examiner	resulting in death) Last  C  Due to (or as a consequence of):							
		edical	d	(F 97 E						
Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year				
P.O.	at the de by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		OO2 Did tobo	acco use contribute to the cause of death?				
rds,	puires that signed a signed and the de	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part i.		2 No 3 Probably 4 Unknown				
Seco	2 8 2	Completed			24a. Was an autopsy perform	24b. Were autopsy findings available prior to completion of cause of death?				
ital	ysician: The is certificate hidirector, page	Be Cor	25. Was case referred to medical	26. Place of Dea		MONO 1 □Yes 2 NO				
Division of Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director,		examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati  27. Manner of Death  28a. Date of Injury 28b. Time	of 28c. Injury at	lome 5 Resider 28d. Describe how	nce 6 Other (Specify) v injury occurred				
sion	tending leath. tor: Afte the fune	cation	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, s	M 1 ☐ Yes 2 ☐ No	28f Location /Str	eet and Number or Rural Route Number,				
Σ	tal or A	Certification: To	4 ☐ Homlcide determined building, etc. '(Specify)		City or Town,	State)				
/	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)				
/	To the vithin 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)				
•		-	30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	0012/10 1	1001				
	Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	le Hill CT. Luth	envirie, r	10 21013				
	Regist		MAY OG 2009 Cerus B. A	arke						

Registrar DHMH 17 Rev 1/2001

State

MAY 0 6 2009

2009

MECKEL

4 LBERT

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For Registrar Ce	artment of Health and Me rtificate of Death	Reg. N	0.2009 14581
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Earl F. Matthews		2. Date of Death Month  May 4, 200	
Examin		4a. Facility Name (If not institution, give street and number)  College Manor	4b. City, Town, or Location of Death Lutherville		Baltimore
Funeral Director		5. Social Security Number 6. Sex 1 XM 2 F 7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea 5/31/1916	9. Birthplace (State or Foreign Country) Maryland
e Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  MD Baltimore Luthervi			10d. Inside City Limits 1 □Yes ¾√XNo
h with the	al Director	10e. Street and Number 300 W. Seminary Ave.	10f. Zip Code 21093		Citizen of What Country?
be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, it is it offed Exerting must be notified at	Completed by Funeral	11. Marital Status  1  Never Married 2  Married  1  Yes, Give Year or Dates: WWII  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes, Give Year or Dates: WWII  15. Decedent's Education (Give life.)  College (1-4or 5+)	Was Decedent of Hispanic Origin? (Speiffyes, specify Cuban, Mexican, Puerto F  1  Yes 2  No Specify:  Indent's Usual Occupation  In think of work done during most of working DO NOT use retired)  P Telephone	16b.	14. Race - American Indian, Black, White, etc.  Specify: White  Kind of Business/Industry  uman Resources
e filed w al Hygiei other th	Be Col	12 C &	18. Mother's Name	(First, Middle, Maid	
should be nd Menta marked imatic ev	10 E	Noah F. Matthews	Mae I.	(Not Know	
ind 2 sh alth and 27 Is in er traum		1	Sweet Air Road Ba		
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev once.		1 Secretarian 2 Cremation 3 Hemoval from State 4 Donation 5 Other (Specify)	Valley Mem. 5/6/20	009 Tii	Location - City or Town, State monium, Maryland
permit. Depart Import any inj once.			2. Name and Address of Facility Tov	wson, Mar Home, In	yland 21204 c. 1050 York Road
death certificate be executed  ### Addical and care as the burial-transit  #### Addical and care as the burial-transit  ###################################	edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if the cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	nter the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death
0 0	Physician/Medi		☐ Ectopic pregnancy ☐ Other (specify)	_	23d. Date of delivery Month Day Year
requires that the de seen signed by the a nould be detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
sıclan: The law requir s certificate has been si irector, page 2 should I	Completed	Distretes mellitus		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
siclan: certificative irrector, p	o Be C	25. Was case referred to medical examiner?  1 Yes 2 No    Hospital: 1   Inpatient 2   ER/Outpatient	26. Place of Death		e 6 Other (Specify)
or Attending Phy fter death. irector: After this n by the funeral d	Certification: To	27. Manns of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day, Year)  28b. Time (Month, Day, Year)  28b. Place of Injury - At home, farm, s building, etc. (Specify)	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	njury occurred  t and Number or Rural Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled it	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	red at the time, date	and place, and due to the cause(s)
To the within To the comp	Me	30. Name and address of person who completed cause of person (Item 23a) (Type A), A, R, Ley EAMC E76(	29c. License number  25 25 26 5		Date signed (Month, Day, Year)  147 4, 2009
		W. A. R. Ley Chine E 70 (	M. Charles J	t. Ba	60. md 21 20x
Sta Registi		31. Date filed (Month, Day, Year)  NAY 0 6 2009  Registrar's Signature	wed		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		٠	For State Registrar	State of Ma	•	•	ificate of L			Reg. No.	2009	14582
	Physicia		1. Decedent's Name (First, Middle, La: Pauline T.	•					2. Date of De Month May	ath Day 4	Year 2009	3. Time of Death 12:09 A. M
170	/Medic Examin		4a. Facility Name (If not institution, giv			4		Location of Death	, id	4c.	County of Deat	h
محمدية	Funeral Director		Gilchrist Ho 5. Social Security Number 064-28-3688 1		(In yrs. last birt		TOWSO	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 3/31/	rth ay, Year)	9. Birt	hplace (State or Foreign untry) YOTK
70		tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Balti	more	10c. City, Town	n or Loca MOni						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23a or 28a	al Director								Ū:	zen of What Co nited S of Amer	tates
960	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examination routing an examination of the Medical Examination of th	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			as Decedent of H 'es, specify Cuba	ispanic Origin? (Sp in, M <i>e</i> xican, Puerto <i>Specify</i> :	ecify Yes or No Rican, etc.)			nite
1215-0	within 72 ho ene. <b>than "natu</b> ie Medical	Completed by	15. Decedent's Et (Specify only highest grade) Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5		(Give kii life. DC	nt's Usual Occup nd of work done of NOT use retired	during most of work	ing	] 1	nd of Business/ New Yor ublic S	k
Maryland 21215-0036	ould be filed v Mental Hygid arked other i atic event, the	To Be Co	12   17. Father's Name (First, Middle, Last, Deyo Trowk)		<u>4</u>	16	acher	18. Mother's Name Nellie	e (First, Middle	, Maiden		
	and 2 should ealth and Mer n 27 is marke her traumatic		19a. Informant's Name/Relationship (	Type. Print) G ddington/N	iece	2110	Folksto	and Number or Rui DNE Road		um, 1	Marylan	d 21093
Baltimore,	Pages 1 nent of H int; If iter iry or oth		20a. Method of Disposition  ↑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	20b. Place of cemeter Butte	rnut	tion (Name of tory or other place Valley	Cem. May	009	Garr		le, New York
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licer	SSA		179	2325	York Ro	ad Tim	oniu	&Cremat m, Mary	ion Ctr.,P.A land_21093
	Physician /Medical		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir	the death. Do rie.	2	the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence (	of):						
68760, 5	tificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as	a consequence (	of):						
P.O. Box 68	- U G	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	23c. If yes, outcome 1	2 Fetal death		Ectopic pregnand Other (specify) _	у			23d. Date of de Month	livery Day Year
rds, P.	quires that n signed build be deta	by	Part II. Other significant conditions	contributing to death bu	ut not resulting ir	n the und	lerlying cause giv	en in Part I.			,	o the cause of death?
al Records,	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Completed							1 □ Yes	opsy formed? 2 M No	prior to death?	utopsy findings available completion of cause of
f Vital	nysician nis certil directo	lo Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Ou	utpatient	3 □ DOA Oth	26. Place of Dea er: 4 ☐ Nursing H			6 Other (Spe	ecity) hospile
o uo	nding PI th. : After the funeral	tion:	27. Manner of De th 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	ry 28b. 1	Time of Injury	28c. Inju	ryat k? Yes 2 □ No	28d. Describe	how injur	y occurred	
Division of	al or Atter s after dea al Director ed in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	20e. Place of Itil	ury - At home, fa c. (Specify)	arm, stree	et, factory, office		28f. Location City or To	(Street and own, State	nd Number or Fl	ural Route Number,
)	he Hospit in 24 hour he Funera pletely fille	Medical (	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examination ar					e, date and	d place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	lus			29c. Licens	5830	3	29d. Da	te signed (Mon	tn, Day, Year)
•	4		30. Name and address of person who	AARVES	(M)	(Type, P	41 /	Charles	ST	Ton	1701	MD.
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 0 6 2009	32. Registr	ar's Signature	ark	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23 Month Year **Physician** 1804 PM PEARL -0013 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Bay view Medical BAltimore Johns If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
2-2-1940 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral x**M 2□ F Months Days Hours Min 69 Director 218-36-2942 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Expriner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1▼Yes 2□No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21224 SA 133 N. Glover Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Goetz Candy Factory 12th grade N/A Fork Lift Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Raymond James Pearl, Sr Sarah Lee Williams ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 133 N. Balto, MD 21224 Marietta Pearl-Wife Glover Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus 5-7-2009 Balto, MD 22. Name and Address of Facility March F/H 21. Signature of Funeral Service Licenses 21202 1101 E. North Avenue Balto, MD an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rnoumoni A month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijusy that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an page 2 s autopsy perform certificate 1 ☐Yes 2 No r this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes after death Director: A 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi-29c. License number

State Registrar RES

Avenue

Baltimore

21224

Doctor

Medical

4940

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAtherly

31. Date filed (Month, Day, Year)

MAY 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 02Day  $a_{M}$ 2009 **Physician** May 05:30 Blanche Pressman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pasadena Anne Arundel Pasadena Home Care If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Hours Days 1 □ M 2 🔀 F Maryland 216-07-9527 92 Yrs 08/29/1916 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Exercitive rought to confifted at 28a-f shov 1 ☐Yes 2 ☐No Funeral Director Anne Arundel Glen Burnie MD filed within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 United States 8225 Anglers Edge Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White Be Completed by 3 X Widowed 4 □ Divorced "natural" 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental h Bernice Lotus Fabian Vecerskis 2 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S Pages 1 and 2 s ment of Health ar Mrs. Susan Pressman-White (Daughter) 8225 Anglers Edge Crt., Glen Burnie, MD 21060 Health em 27 is permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/08/2009 | Baltimore, Maryland Most Holy Redeemer 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature f Funeral Service Lice Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or pach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav Year in the past 12 months 5 Other (specify) 1 ☐Yes 2 ☐No the detached 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe certificate 2 PNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Assiste Other: 4 Nursing Home 5 Residence 6 Tener (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No death. 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

P.0. Records, Division of Vital

Box 68760

within 24 hours a To the Funeral D Hospital the

State

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

m) Registrar's Signature 31. Date filed (Month, Day,

who completed cause of death in

and manner stated

em 23a) (Type, Print)

1 Ceftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25tate of Maryland 28a f per me, 88 th on Mantal Hygiene 2 Certificate of Death Reg. No. 1 - For A State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CATHERINE E. OUINN MARCH 22, 2009 8:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner 6819 BANK STREET BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2**X** F AUG. 9, MARYLAND 109-16-5536 1923 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County d other than "natural", or items 23a or 28a-f show event, the Madical Event near that be notified at XXYes 2 □ No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 6819 BANK STREET 21224 Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene.

Is marked other than "natural", or iter 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: WHITE 2 Specify: 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be O'CONNOR ANNA FREDERICK JOHNSON traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any Injury or other trauonce. 6819 BANK STREET, BALTIMORE, MARYLAND JAMES QUINN/SON 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 OAK LAWN CEMETERY 3/25/2009 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Fracture Left Hip cockyx s/p fall Immediate Cause (Final disease or condition resulting in death) **Physician** CHICH APPROVED BY WEDICAL EXAMINER /Medical End Stage Renal Misease Due to (or as a consequence of Examiner 17510 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c Examine Hypertension that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Chronic Obstructive Pulmonary Di Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached f ☐Yes 2. No P.0. 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury 12/30\*/08\*\* 02/13/09 27. Manner of Death 28b. Time of 28c. Injury at Work? Subject tripped and fell; Certification: 3:30 pm &M 5 Pending investigation Accident 1 ☐ Yes 2X No Subject fell out of bed. after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 6819 Bank St., Balto, MD, and 6600 Ridge Rd., Rosedale, determined 4 ☐ Homicide and Nursing Home Home within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Pate signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 2122/2 3509 Eastern Avenue MO

State Registrar Nukesh

31. Date filed (Month, Day, Year)

Luhar

0 5 2009

DHMH 17 Rev 1/2001

1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** MARLENE ROGERS Α. 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sauane If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 / 07 / 1936 9. Birthplace (State or Foreign (In yrs. last birthday Social Security Number **Funeral** Days Months Min MARYLAND 1 □ M 2 □XF 72 Director 219 32 8570 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must by retified at 1 ☐ Yes 21 No Director MD BALTIMORE ROSEDALE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 6306 MAGDOLENA ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. BUSINESS OFFICE MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be DAMASIEWICZ HELEN NOWAK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 4 4 2 9 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 JAMES McCABE / NEPHEW 6209 WEST GLEN ROBBIN CT. CRYSTAL RIVER, FL 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ᇹ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If it any injury or c OAKLAWN CEMETERY 5/7/09 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respire try arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner ntracerebi if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): APPRIVED BY MEDICAL EXAMINER Hypertension law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): CERTIFICATIO Box 68760. attending physician Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknow signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA vision of this Certification: To o the Hospital or Attending Phithin 24 hours after death.
o the Funeral Director: After the ompletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled i † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ran Month, Day, State Registrar

DHMH 17 Rev 1/2001

09-03579	
Cynthia Rice	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

nthia Rice	1.	State of Maryland / Department of Health and Inc. 1- For State Certificate of Death	Reg. No.	2009 1458
Physicia	R	Registrar	2. Date of Death Month Day May 4, 2009	3. Time of Death Year 0355 hrs
edical Examin		4a. Facility Name (if not institution, give street and number)		County of Death
Euparal		15 Social Security Number 16, Sex 17, Age (III yis: ldst Shardsy)		D/YYYY) 9. Birthplace (State or Foreign
Funeral Director		215-84-3791 1 M 2 LF 46 Yrs. Months Days	Hours Min. Jan 24, 19	
/ any		Usual Residence of Decedent  10a. State  10b. County  Battimore  10c. City, Town or Location  Windson	- Mill	10d. Inside City Limits 1 Yes 2 No
or 28a-f show	Director		1244 10g. Citiza	en of What Country?
th the Ma 23a or 29 notified	Die	2106 Caybrok Kd.  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa	anic Origin? ( Specify Yes or No-	4. Race - American Indian, Black,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral	Armed Forces?  If Yes, specify Cuban, I Yes 2 No	Mexican, Puerto Rican, etc.)	White, etc.  Specify: Black—
hours after 'natural'', Examiner	<u>a</u>	or Dates:  15 Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation	n (Give kind of work done 16b. K	ind of Business/Industry
hin 72 hc. e. than "n: edical Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)  Personal	rainer	Private
21215-0036 Uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Be Con	Callilla Stare	8.Mother's Name (First, Middle Maiden Emma Mae Ricu	
imore, MD 21215-003. Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. ant: If item 27 is marked other the or other transmatic event, the Mec	To B		and Number or Rural Route Number, Ci	r Mill, Mayland
rate and rate	i	20a. Method of Disposition (Name of Certain Country of Other place)	etery, Date 20c. I	Location - City or Town, State  Asdowne Maryland
Baltimore, permit. Pages 1 a Department of He Important: If it injury or other t		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Secret Ce Licensee 22. Name and Address	019	1. Home, P.A. 24229.
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying.	derick Ave Basuch as cardiac or respiratory arrest, sho	ock, or heart Approximate Interval Between Onset and
Physician *ledical		failure. List only one cause on each line.  Hypertensive cardiovascular	disease complicat	ed by Death
aminer		or condition resulting in death)  Due to (or as a consequence of): COCATHE USE		~
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
d d ansit	Examiner		ויין אין אין אין אין אין אין אין אין אין	
50, te be executed ysician and burial - transit	edical	AMENDED 23a,27,permE, g891 5/		3d. Date of delivery
Records, P.O. Box 6876 The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the t			Ectopic pregnancy	Month Day Year
Box 6876 ne death certificate the attending physel	Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	are critical and a second	o use contribute to the cause of death?
P.O. es that the signed by be detacl	d by F	<u></u>	1 Yes 2	No 3 Probably 4 ✓ Unknown  24b. Were autopsy findings available
ords, aw requii as been	Completed		autopsy performed	prior to completion of cause of death?
	e Con	25. Was case referred to medical	e of Death (Check only one)	
f Vita Physicia er this ce	To B	examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA	Other Nursing Home 5 Resi	dence 6 Other:
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the raster death.  **An Director. After this certificate has been signed by lied in by the funeral director, page 2 should be deated.	ation:	1 X Natural 5 Pending (Month, Day, Year) 1 1	Yes 2 No	t and Number or Rural Route Number, City
Division of Vital Records, P.O. Box 6876 upital or Attending Physician: The law requires that the death certificat curs after death.  reral Director: After this certificate has been signed by the attending physician Age of Should be deatabled for use as the filled in by the fineral director, page 2 should be deatabled for use as the	ertific	28e. Place of Injury - At nome, farm, Sireet, factory, office determined (Specify)	or Town, State)	
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certif		Certifying Physician: To the best of my knowledge, death occurred at the think of one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion	late and place, and due to the cause(s) n, death occurred at the time, date and	and manner as stated. place, and due to the cause(s)
To the state of th	Med	29b. Signature and title of certifier	se number 29	d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)		
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltin	nore, MD 21201	
Reg	Stat stra	ate of ball field (Month, Sey, Sen)		
DHMH 17 Rev	/2001	ORIGINAL ORIGINAL		

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Ernestine Rounsaville 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Plata Civista La narle 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, )
Oct. 12, Age (In yrs. last birthday) Year) 1 □ M 2 🖾 F Months Days Hours Yrs. 235-68-9031 65 1943 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 616 Garner Avenue 20602 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: Black 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank G. Singleton Harriett Brown 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 Garner Avenue, Waldorf, MD 20602 Sheila Rounsaville-Woods 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Hope Cemetery May 9, 2009 Martinsburg, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licenses 22. Name and Address of Facility Brown Funeral Home King Street, Martinsburg, WV 25401 Dun 23a. Part 1. Enter the disease, or complications that earlied if shock, or heart failure. List only one cause of each line immediate Cause (Final Approximate Interval Between Onset and Death p not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or Due to (or as anconsequence of): D84 23d. Date of delivery 23b. Was decedent pregnant

**Physician** /Medical Examiner

permit. Pages Department of Important: If it any Injury or o o

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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MD

**Funeral** 

Director

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Eventions in ust be notified at

1 and 2 should be filed within 72 hours after Health and Mental Hygiene.

2121

Baltimore, Maryland

P.O. Box 68760,

Division of Vital Records,

Rounsaville

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

First Director: After this certificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burish-transit

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last
IF FEMALE:

in the past 12 months?
1 ☐ Yes 2 ☒ No

25. Was case referred to me

1∐ Yes 2D No

27. Manner of Deal Natural

2 Accident

4 Homicide

3 ☐ Suicide

Part II. Other significant conditions contributing

5 Pending

Sein

MAY 0 6 2009

31. Date filed (Month, Day, Year)

6 Could not be

determined

00.16
23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deat
4 ☐ Pregnant at time of death
9 🔲 Unknown

3 Ectopic pregnancy

5 ☐ Other (specify)

g in the underlying cause given in Part I.

Month

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown

performed 1 ☐Yes 2 🛛 No 26. Place of Death (Check only one)

24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Year

	Inpatient 2	ER/Outpatient	3 □ D	OA Other: 4	☐ Nursing H	ome	5 🗌 Residence	6 ☐ Other (Specify)
Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes	2 □ No	28d.	Describe how inj	ury occurred

M 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only	Certifying Pl	hysici: miner:	9h	th <b>g</b> basis of examination and	, death occu d/or investiga	rred at the time, date and place, and due to the ation, in my opinion, death occurred at the time	he cause(s) and me e, date and place,	anner as stated. and due to the cause
one)			and	manner stated.				
29b. Signature and	title of certifier	.//	1			29c. License number	29d. Date signe	d (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

State Registrar

within 24 hours To the Funeral

completely

State Registrar A BURTH

6701 N, Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 CRS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MEND, TTEM#17.18&22 per INF (891 5/19/09 WS)
State of Maryland, Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year 2:30 P M May 2, Theresa Ribecky Margaret 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Co. Dundalk Apt. F 3112 Wallford Drive 8. Date of Birth (Month, Day, Year) March 6,1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours Min. 1 □ M 2 🗓 F Mary land Yrs. 88 217-09-1211 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Dunda1k Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States Apt. F 21222 3112 Wallford Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Bookkeeper 12 Years 17. Father's Name (First, Middle, Last)
Ribecky 18. Mother's Name (First, Middle, Maiden Surname) Slezak Theresa Joseph 👯 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nottingham, Maryland 21236 19a. Informant's Name/Relationship (Type. Print) Dolores Welsh (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/8/2009 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address **Functial**Duda-Ruck <del>Fuental</del> Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final troke minutel disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy perform 1 ☐Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner Examine

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

28a-f show

Director

by Funeral

Completed

Be

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r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 2700 any injury or other traumatic event. The Mental Process.

with the Maryland

attending physician and for use as the burial-tran been signed by the should be detached certificate has be irector, page 2 s funeral director, After this nours after death.

neral Director: Af

filled in by the fur

Physician/Medical

Completed by

Be

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

9 Unknown

25. Was case referre examiner? 1 ☐ Yes 2 ☐ N	
27. Manner of Death	
1 Natural	5 Pending

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 \sum Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

investigation 2 Accident 6 ☐ Could not be determined 3 Suicide

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

4 Homicide

La CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number 042232 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott -er ser 21/2 Dundalk 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar



within 24 hours af

To the Funeral D

completely filled i

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200<sup>Year</sup> Month Day **Physician** 2, Irene W. Rassa May 10:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Blakehurst Towson Baltimore 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Oct. 20, 1915 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□XF Months Days Hours Min. Oct. 93 Pennsylvania Director 220-24-5078 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location other traumatic event, the Medical Examiner nust be notified at 1 ☐Yes 2 → No Funeral Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1055 W. Joppa Road #535 21204 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Completed by white 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Owner Dance Studio 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John L. Czechowski Regina ္က 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Rassa son 2260 Engle Road; Fallston, MD 21047 Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗌 Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens 5/7/09 Timonium, MD 5 DXOther (Specify)entombment 4 Donation 22. Name and Address of Facility 1050 York Road 21. Signature of Ruck Towson Funeral Home Towson, MD 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Imonau disease or condition resulting in death) /Medical Tue to (or as a consequence of): **Examiner** 2 monon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Bue to (or as a consequence of) Examiner Due to (or as a consequence of) Box 68760. Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s after deam. ral Director, After this cerum. in by the funeral director, pe 2 No 1 ☐ Yes 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospita 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and title of certifier 29b, Signature m

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

MAY 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANKS

32. Registrar's Signature

		1 - State Registrar 1. Decedent's Name (First, Middle, Las	State of Marylan	Cer	tificate of L			Reg. No.	3. Time of Death	
Physi /Me/	ician dical	John		SY	nith		Month	Day 9	2009 12:21 PM	
Exam		4a. Facility Name (If not institution, give		_		Location of Deat	th	4c. County		
	. A.	The Johns Hopkins H  5. Social Security Number 6. S		last hirthday)	Baltimore If Under 1 Year	City If Under 24 Hrs	s. 8. Date of Bir	th	Birthplace (State or Foreign	
Funera Directo	_	1	X M 2 □ F 76	Yrs.	Months Days	Hours Min	. (Month, Da	y, Year)	Country) V.A	
pu. »		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo	ootion		10 2	2 32	10d. Inside City Limits	
Manyla f sho	٥			B <b>alti</b> r					1 Yes 2 No	
death with the Maryland ems 23a or 28a-f show must be notified at	Director	10e. Street and Number			10f. Zip-Code		/hat Country?			
tth wit 23a c 1st be			Drive		2]	1215		U.	S.A.	
ie it e	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 14. Race Black	e - American Indian, k, White, etc.	
036 urs aft at", or 'xamir	2	3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specity:		Specify.	Black	
Maryland 21215-0036 d.2 should be filed within 72 hours after death with the Marylan th and Mental Hygleine. The single of the stream of the streams arked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of we	orking	16b. Kind of Business/Industry		
121 within sne. than "	am	Elementary/Secondary (0-12)	College (1-4 or 5+)				Ü	Chomic	al Companies	
d 212 filed withi Hygiene. other than ent, the M			na	Maci	nine Ope		ame (First, Middle	, Maiden Surnam		
should be and Mental marked o	To Be		Smith			Annie Bell D		illard		
re, Maryla s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (7	ype. Print)		_					
		Grace Smith Wi				ous Dri			, Md 21215	
		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	osition (Name of matory or other place		Date		City or Town, State	
Baltimo permit. Page Department of Important: If any injury or	once.	21. Signature of Funeral Service Licens		Woodl	<u>awn</u> 2. Name and Addre arch F/E		3/2009	Woodla	wn, Md	
Physiciar /Medica Examine		23a Part 1. Enter the disease, or companies shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	b. Ventricula	h. Do not ent lure luence of):	300 Waba er the mode of dyi	ash Ave			Md 21215  Approximate Interval Between Onset and Death	
68760, x tificate be executed g physician and as the burial-transit	edical Examiner		c. Myo cardifo	al info	irction					
D. BOX he death cer the attendin ched for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1  Live birth 2  Feta 4  Pregnant at time of d 9  Unknown	al death 3	☐ Ectopic pregnand ☐ Other (specify)	ey		23d. Dat Mor	e of delivery nth Day <b>Y</b> ear	
S, P.	by P	Part II. Other significant conditions of	ontributing to death but not res	sulting in the	underlying cause g	iven in Part I.			ribute to the cause of death?	
cord  v require been sig	eted			-			1		3 Probably 4 Unknown	
	Completed						24a. Was autoj perfo 1  Yes	osy prmed? c	Were autopsy findings available orior to completion of cause of death?  1 Yes 2 No	
Vital Sician: The certificate irector, pa	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	ot 3 DOA Oth	er.	ath (Check only o	<i>ine)</i> dence 6 □ Othe	or (Pageita)	
on of Jing Phys h. After this funeral d	- - -	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	IL 3 DOA	y at		how injury occurr		
VISI Attend deat deat ctor:	ertification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined			M 1 🗆	Yes 2 □ No	28f. Location (		er or Rural Route Number,	
To the Hospital or / within 24 hours after To the Funeral Dire	edical C	29a. Certifier 1 Certifying Ph (check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	n occurred at the till vestigation, in my o	me, date and place	ce, and due to the curred at the time	cause(s) and ma , date and place,	inner as stated. and due to the cause(s)	
To the within 2 To the Comple	¥	,	my, M	·		e number S - OOC			1 (Month, Day, Year) 2, 2009	
		30. Name and address of person who April Villama		m 23a) (Type	Print)	600	North Wo	olfe St. Ba	Itimore, MD, 2128	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture				,	,,	

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18, per FH & 19a, per Inf G891 5/11/09 TT

State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 **Physician** 2009 Anthony Scheel, Jr. 04:45 a<sup>M</sup> Nicholas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARKETTS VICLE MADONNA HERITAGE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 09/21/1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Mary land 1 X M 2 □ F 219-18-6744 84 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland of Hygiene.

I Hygiene.

The state of the st 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 M No Director Jarrettsville MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21084 3982 Norrisville Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City Of Baltimore C.P.A. h and Mental Hygie 18 Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any light yo other traumatic event store. 17. Father's Name (First, Middle, Last) Be Mary Beckman Nicholas Anthony Scheel, Sr. ၉ 19a. Informant's Name/Relationship (Type. Print)

Marie Smith, Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Yvette Drive, Forest Hill, MD 21050 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/09/2009 Baltimore, Maryland Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Olxondria & Blai Þ 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 year **Physician** disease or condition resulting in death) HYDRG CEPH ALUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): P.O. Box 68760 signed by the attending physician d be detached for use as the buria the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) I Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, EMPH 15Ema /cord 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? A.F.B 24a. Was an has autopsy performed' DEMENTIA 2 🗆 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes e Hospital or Attending Physician: '24 hours after death.
e Funeral Director: After this certifica 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ∠1 ✓ 1 ✓ 2 1∐ Yes 2 ☑ No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 31295 515/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

State Registrar Kuiss2

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31. Date filed (Month, Day, Year)

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21206

5701 KENWG: 0

Registrar's Signature

09-03484 William Stroble

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 14594

		1- For State Certificate of Death Reg. No.						
Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  4.640 have	٦					
ledical Exami		William B. Stroble, Jr. April 30, 2009	4					
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	1					
		2202 Eastern Avenue Baltimore	┙					
Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY)  Months Days Hours Min.  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	,In					
Director		219-16-9862   1XM 2 F   82 Yrs.   World S   11/08/1926   Maryland	┙					
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w any		10a. State 10b. County 10c. City, 10wii oi Eccation 1	- 1					
Maryland 28a-f show 1 at once.	٦	MD Baltimore City Baltimore	4					
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?						
the]		2202 Eastern Avenue 21231 U.S.A.	4					
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black, 15. White, etc. 14. Race - American Indian, Black, 16. White, etc.						
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with ber t		12 Letter Carrier U.S. Potal Service  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	$\dashv$					
215-0036 be filed within 7 ntal Hygiene. rked other than	C							
212 ould be Ment mark c ever	0 0	William B. Stroble, Sr.   Sophie Kowalski  19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
b, MD 21215-0036 and 2 should be fited within 72 hours after death with the Maryland featth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	7	Mary Stone (niece) 1805 Alpine Drive - Forest Hill, Maryland 21050						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	ı	20a. Method of Disposition						
Baltimore, permit. Pages I ar Department of Hee Important: If itel		Abunal 2 Cremation 3 Removarion state						
Itin nit. P artme ortan		4 Donation 5 Other Specify: Highview Memorial Gds.05/04/2009 Fallston, Marviand  21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P. A	$\overline{}$					
Balti permit. Departu Imports injury o	8 (8	11750 Relair Road - Kingsville, Maryland 2108	37					
Physician	$\neg$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or near						
/Medical	i u	failure. List only one cause on each line.  Immediate Cause (Final disease a, Hypertensive Atherosclerotic Cardiovascular Disease Death	- 7					
`xaminer		or condition resulting in death)  Due to (or as a consequence of):	Т					
		Sequentially list conditions, b.	—					
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
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cuted nd transi		d						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED X AMENDED 16b, per Fh g891 5/6/09 TT						
760 cate b physic		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery  When the Day Year						
OX 68: ath certifi attending or use as	ian	23b. Was decedent pregnant in the past 12 months?    1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   Ye						
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.O. Be that the de ned by the detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?						
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COT law I has b	ldu	performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No						
Division of Vital Records, pital or Attending Physician: The law requireral Director: After this certificate has been s filled in by the funeral director, page 2 should I	ပို							
ician s certi	Be	examiner? Hospital: 1 Innation: 2 FR/Outnation: 3 DOA Other; Nursing Home 5 Residence 6 Other: Scene						
of Vir Physic er this eral dir	ျ	1 V Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred						
n of iding Pl fh. : After e funera	<u></u>	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No						
Signature de la desta de la de	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Ci	ty					
Divisior  Bospital or Attend 24 hours after death Funeral Director: etely filled in by the	Certification:	Suicide Could not be determined (Specific)						
lospit Thour uners		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	1					
To the Hos within 24 h To the Fun completely	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
P. W. P. IO.	Me	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)						
		O.C.M.E. May 1, 2009						
		30. Name and address of person who completed cause of death (Item 23a)						
1211/		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
Regis		A CONTRACTOR OF THE PROPERTY O	_					
DHMH 17 Rev 1/	2001	ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) 14595 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Burnetta Stafford 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Genesis Loch Raven Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) ADTIL 1 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 D€ Hours Min. Baltimore Maryland 215 09 8364 90 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Baltimore Baltimore County Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Exa<u>miner must be 1</u> 21236 LISA 5 Elinor Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after whealth and Mental Hygiene. Health and Mental Hygiene. Sm 27 Is marked other than "natural", or Itel 2 □ No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Specify. 3 Midowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hochschild-Kohn Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Hooper Raymond Joseph Sweeney ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Elinor Avenue Baltimore, Md. 21236 Shirlev A Mills permit. Pages 1 and Department of Healt Important: If Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State injury or Woodlawn Cemetery May 6 2009 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home Inc. 21. Signature of Funeral Service Licensee any 7401 Belair Road Baltimore, Maryland 21236 e, or complications that caused the List only one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease shock, or heart failure. th. To not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed 2 No or Attending Physician; funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 1 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

06 2009

UU

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me, 291,05/05/09dhb Reg. No. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April **Physician** 2:30 2009 Рм Grace т. Shaprow 15. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2X F 97 Mary land 220-54-7770 Director 11/17/1911 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed at once. 1 ☐ Yes 2 🛛 No MD Baltimore Parkville Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 8820 Walter Blvd. #2513 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) At Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William H. Thomas Lillian Irene Chitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2607 Ivy Place, Parkville, MD 21234 William Shaprow, Sr. / Son 20b. Place of Disposition (Name of Moreland Variation (Name of Moreland Memorial 04/18/09 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burlai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkville, MD Park 21. Signature of Funeral Service Licensee

Evan's Funeral Chapel & C.
8800 Harford Rd. Parkvil

23a. Parl J. Enter In disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or he in failure. List only one cause on each line. EV Anns and Address of Facility Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death Immediate Cause Final dise se or condition resulting in death) Physician 7days cerebrovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-transit for pr. Tito Due to (or as a consequence of): 5race Sha from 100 W 17 M Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 MNo Day 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ left tibial plateau fracture, dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 100 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month. Day, Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 6:00 p M 03/27/2009 1 ∐Yes 2 X No Subject fell within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8832 Walther Blvd. Parkville, MD 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Care Center 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D61785 address of person who completed cause of death (Item 23a) (Type, Print) Walther Boulevard, Parkville, MD 21234 State Registrar

7

Dob; 4/15/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:09 4 2009 JOYCE LAVERNE May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗖 F 213-64-6021 MD. 55 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f shovevent, Inc. Medical Examiner must be notified at FREDERICK MD. BUCKEYSTOWN 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA MANOR WOODS 21717 6703 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK If Yes, Give Year or Dates: Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WELLS FARGO f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SPECALIST MORT GAGE 12 114 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY NAYLOR LAYER DAVIO ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (day) BARNES 7495 FAIRPOINT RD FAYETTEVILLE, N.C. 28384 DAWNETTE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important; If iter
any injury or ott MAY 8, 2009 FRED, MD. Burial 2 Cremation 3 Removal from State PAIRVIEW Com. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN. Home 21. Signature of Funeral Service Licenson FLEDERICK MO 21701 ollis Jung d. 110 WEST SOUTH ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ardiac Arre /Medical Due to (or as a consequence of): Examiner morectal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Anemia. burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □Yes 2 ☑No Month Day 5 Other (specify) P.O. been signed by the should be detached a∏IJnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an cate has to page 2 sl autopsy performed? certificate or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this ( Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director; A

completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

Hemen shah 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Thomas C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson Dr

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D60417

29d. Date signed (Month, Day, Year)

Frederick MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** arc /Medical 4c. County of Death Town, or Location of Death 4a. Eacility Name (If not institution, give street and number) Examiner 5X( Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 – 25 – 1958 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Maryland 50 216-72-6003 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Western Examiner must be provided and 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1X Yes 2 □ No MD **Funeral Director** N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21224 905 S. Fagley Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) N/A Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Jean Chalk Charles Riser, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband Baltimore, MD 21224 S. Fagley Street Ronald J. Shears,Sr. 905 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3-31-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Li 1201 Dundalk Avenue Barltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 disease or condition resulting in death) /Medical Due to ( Examiner APPROVIED BY MEDICAL EXAMINER Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner In M 11243 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a er death.

To the Funeral Lirector: After this certificate has been signed by the attending physician and completely filled in by the fur eral director, page 2 should be detached for use as the burial-transit CERTIFICA Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2. ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 ØÑo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XYes 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only ne) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of contifie Mayor 27, 2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL PL BULT TMOVE, MOHIOS MA filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 5 2009 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 14599

	1- For State Registrar	Certificate of De	eath		g. No.		
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)			2. Date of Death Month April 22, 20	Day Year	3. Time of Death 2131 hrs	
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death			4c. County of Death		
	St. Agnes Hospital  5. Social Security Number		altimore Under 1 Year   If Under	24Hrs 8 Date of Birth	n/a	nolace (State or	
Funeral Director	215-50-2601 1 M 2XF	· · · · · ·	Months Days Hours	Min. 10/10	Foreign	Foreign	
any	Usual Residence of Decedent         10a. State         10b. County         10c	c. City, Town or Location				10d. Inside City Limits	
Maryland 28a-f show any datonce. ector	MD n/a	Baltimor	ce			1 X Yes 2 No	
ith the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 1632 Foresthill Avenue	10	f. Zip Code 21230	10	g. Citizen of What Coun	try?	
fter death wi ", or items er must be r/ Funer	3 Windwed 4 Hivarced III tes, Give tear	If Yes, s	ecedent of Hispanic Origin specify Cuban, Mexican, Fig. 2 $X$ No specify:		14. Race - Americ White, etc. Specify: Wh	ite	
1215-0036 Ide filed within 72 hours aft fental Hygiene. narked other than "natural" event, the Medical Examine or Be Completed by	15. Decedent's Education (Specify only highest grade comple		Isual Occupation (Give kinds)  of working life, DO NOT u		16b. Kind of Business/Ir	ndustry	
15-0036 filed within 72 hour al Hygiene. ed other than "natu t, the Medical Exan e Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Factory	Worker		Manufacti	rina	
215-0036 be filed within 7 mal Hygiene. rked other than rent, the Medica Be Comple	17. Father's Name (First, Middle, Last)	1 - 00 - 00 - 1		Name (First, Middle, M		irriig	
21215-00 Detailed with the best of the control of t		Taob Malling Ad	Fra	nces Kell		Zin Code)	
	Ronald W. Sheldon / Husband		oresthill A		•		
	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	20b. Place of Disposition crematory or other p	(Name of cemetery,	Date	20c. Location - City or		
Baltimore, Pernit. Pages 1 an Department of Hei Important: If ite	4 Ponation 5 Other Specify:	Glen Haven	Cemetery 4	4/27/2009_	Glen Burni	e. MD	
Baltimo permit. Page Department of Important: injury or oth	21. Surfatur of Funeral Service Licelisee	22. Name	e and Address of Facility WIlkens Ave	Hubbard Fu	neral Home	Inc.	
Physician	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do not enter the m	node of dying, such as car	rdiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and	
/Medical caminer	Immediate Cause (Final disease a. Hypertensive Athe		ascular Disease			Death	
	or condition resulting in death)  Due to (or as a consequence sequentially list conditions,	ence of):					
ted Insit  Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
uted d ansit		ence of):					
760, icate be executed by physician and the burial - transit //Medical Exa	UNPENDED AMENDED						
certif		2 Fetal d	leath 3 Ectopic (	pregnancy	23d. Date of delivery Month D	Year Year	
		_	rlying cause given in Part	1 23e. Did tot	pacco use contribute to	he cause of death?	
Records, P.C The law requires that ficate has been signed page 2 should be deter Completed by	Chronic infection of knee; obesity; emphyse	ema				opsy findings available	
of Vital Records, g Physician: The law requir of this certificate has been s neral director, page 2 should TO Be Complete.				autops perforr	med? death?	ompletion of cause of	
tal Rec cian: The l certificate l ector, page			26.Place of Death (C		No 1 Ye	s 2 No	
of Vital    og Physician:  free this certif  neral director,	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3	DOA Other	•	Residence 6 Other		
= < .> =		28b. Time of Injury UNKNOWN	y 28c. Injury at Work?	Subject fell o	ow injury occurred luring rehabilitation	1	
Division o spiral or Attending tours after death. neral Director: After filled in by the fure Certification:	3 Suicide 6 Could not be determined (Specify) Other	/ - At home, farm, street, fa (rehab)	actory, office building, etc.	28f. Location (S or Town, St unknown, unkr	treet and Number or Ru ate) nown, MD	ral Route Number, City	
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier  where the state of		29c. License number O.C.M.E.		29d. Date signed (Mor May 4, 2009	nth, Day, Year)	
-	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
State Registra	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar						
DHMH 17 Rev 1/2001 ORIGINAL							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryland / I		rtment of Health and tificate of Death	d Mental F	lygien Reg. N	0000	14600	
			Registrar     Decedent's Name (First, Middle, Las.)				2. Date of Month	Death	Day Year	3. Time of Death	
	Physicia /Medic	al			ate	5	1	2009	4:10 am		
Examiner			4a. Facility Name (If not institution, give			4b. City, Town, or Location of De Baltimore	eath	4	tc. County of Death		
	Funeral		Overlea Health 5. Social Security Number 6. Se	ex 7. Age (In yrs. last bi	rthday)	If Under 1 Year   If Under 24 H	lin (Month.	Day, Yea	9. Birthp	place (State or Foreign	
	Director	n.	212-32-6916	□м 21Д 74	Yrs.	World Days Hours II	4-28	-193	35	MD .	
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Loc	ation			1	0d. Inside City Limits	
Mary	a-f sh iffied	ctor	MD	N/A Balt	imo	re				1 <b>X</b> Xes 2□No	
	vith the	Dire	10e. Street and Number			10f. Zip Code 21225		_	Citizen of What Cour	ntry?	
ite, INICAL FIGURE 2 12.10500 s.1 and 2 should be filed within 72 hours after death with the Maryland f. Health and Menalla Hygiene. filem 27 is anarked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ns 23a must	Funeral Director	410 Patapsco A	12. Was Decedent Ever in U.S.	13. V	/as Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Po	(Specity Yes or		14. Race - Americ		
	irs after d II", or iten xaminer	by Fun	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1	1	Yes, specify Cuban, Mexican, Pe	uerto Rican, etc.)		Black, White, Specify: B1		
5	72 hou natura lical E	ted	15. Decedent's Ed (Specify only highest grad		. Deced	ent's Usual Occupation kind of work done during most of O NOT use retired)	working	16b.	Kind of Business/In	dustry	
7	within sine.	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) N/A		ousewife		I	Home		
yidila ZIZ ould be filed within   Mental Hygiene. narked other than natic event, the M		Be Co	17. Father's Name (First, Middle, Last)	147 11		18. Mother's	Name (First, Mid		len Surname)		
2	should be and Menta s marked umatic ev	To B	James F. Carro				ie Cur				
Z Z	and 2 sho ealth and n 27 Is ma ner trauma		19a. Informant's Name/Relationship (7 Deborah Sorre)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		g Address <i>(Street and Number o</i> O Lorman Ct B			ty or Town, State, Zi <sub>l</sub> 21217	o Code)	
ນົ	s 1 and f Healt fem 2 other	1 8	20a. Method of Disposition	20b. Place of		sition (Name of patory or other place)	Date	20c.	. Location - City or To	own, State	
	Pages nent of int: if i		1  Burial 2  □ Cremation 3  □ 4 □ Donation 5 □ Other (Specify	Hemovai irom State		e_National	-5-2009	Ba	altimore	, MD	
	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility March East F/H  1101 E. North Avenue Balto, Md 21202								
I			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death. Do	not ente	er the mode of dying, such as car	diac or respirato	ry arrest,		Approximate Interval Between Onset and Death	
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a METASTATI		CANCER				onor and boda.	
-	Examiner			Due to (or as a consequence	01):						
	D .≅	ner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury	Due to (or as a consequence	of):						
	xecute and I-trans	Examiner	that initiated events resulting in death) Last								
0/00	icate be executed physician and s the burial-transit	dical E		Due to (or as a consequence	,						
	rtificatu ng phy as the		IF FEMALE:								
J. DOX	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)		_	23d. Date of deliv Month	rery Day Year	
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On or vital moding Physician: The h. After this certificate he funeral director, page	slcian certifi rector	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	) utnation	Other:	Death (Check o		e 6 □Other (Spec	ifu)	
	<b>ਨ</b> €ੁਲੁ	<b>—</b>	27. Manner of Death		. Time of	28c. Injury at Work?	-		njury occurred	1197)	
SIO	Attending r death. ector: After by the fune	catio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 ☐ Yes 2 ☐ No		(0)		17. 1. 1. 1.	
A Manner of Death  1 Matural  2 Accident  3 Suicide  4 Homicide  2 Be. Place of injury - At home, farm, street, factory, or building, etc. (Specify)							tory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical C		ysician: To the best of my knowled niner: On the basis of examination a and manner stated.							
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License number			Date signed (Month		
)			ke ay alakan	λ		D006057	0	MA	17 4,200	9	
1	1		30. Name and address of person who	completed cause of death (Item 23a		^ .	200 1	5~	ran odar da		
0	-		TANKIN KAEHER	22 Registrar's Signature	1/0	מייון אייון	-08,	346	IIM UNCE , TY		

State Registrar

PLE CHARLONIA

MAY 0 6 2009

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 30 **Physician** 2009 9:30 P **URBAN FRANCES** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE ALICE MANOR NURSING HOME Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 07/23/1934 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days NY 74 215-30-6190 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State id other than "natural", or items 23a or 28a-f show event, the "Modical Examiner must be notified at 1 X Yes 2 □ No Director N/A BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21211 2095 ROCKROSE AVENUE Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 □Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 □Yes 2 🕱 No Maryland 21215-0036 Specify ş 3 ☐ Widowed 4 🂢 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill h and Mental F Be UNKNOWN UNKNOWN MCGARRY UNKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health a 2170 SPRINGDALE RD., PASADENA, MD 21122 RICHARD TRUETT / SON Baltimore, Department of Heal Important: If item 2 any injury or other once. Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/04/2009 BALTIMORE, MD BALTIMORE HEBREW 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Fugeral Servic Licen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition resulting in death) Profession Deeh **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed genea sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician; The 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . 821 N. ENTAW STENDE JOS BALTIMOREMP HOASHMI

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**ORIGINAL** 

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 30 8M ace 09 enub 04 /Medical Name (If not institution, give street and permits - Perning 4c. County of Death
Ballingre 4b. City, Town, or Location of Death Examiner Towsor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Menth, Day, 9. Birthplace (State or Foreign 7. Age (In yrs last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Days Hours Min Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State in and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be medified at 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Numbe 10g. Citizen of What 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

COOK Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (Eirst, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ပ္ Department of Health ar Important: If Item 27 Is any infury or other trau 20a. Method of Disposition 20b. Place of Disposition cemetery, crematory 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. proximate terval Between Immediate Cause (Final **Ohysician** DEC PROGRESSIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNKNOWN Dementia Sequentially list conditions, if any, leading to intrincidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transi The law requires that the death certificate be execute therscleratic CARDIONASCULAR and Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Records, P.O. Box 68760, Physician/Medical -AILURE te IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 4 Unknown 2 🗌 No 3 ☐ Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate CANCEROF 1 🗆 Yes Division of Vital LIECVOCIS Hospital or Attending Physician: 25. Was case referred to medical examiner? in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2009

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#6perINF. G892, 6/17/09, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5 28 2009 6:58a APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 210 N. FULTON AVE. BALTIMORE N/A 6. Sex 11 M 2 K If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. Hours Days **Director** TENN 2-12-1922 87 220-22-4474 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Examiner must be notified at Yes 2 □ No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 210 N. FULTON AVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give ☑ Year or Dates: 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2√2 No Specify. Specify: BLACK þ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry traumatic event, I've Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) NURSING HEALTHCARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MATTIE LOONEY 2 THOMAS CHARLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GERALDINE VENABLE-HORTON(DAUGHTER) 210 N. FULTON AVE. BALTIMORE, MARYLAND 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of harmonic limportant: If ite any injury or ott 1 Burial 2 Cremation 3 🗆 Removal from State 5 Other (Specify) KING MEMORIAL PARK 4 Donation 5-4-2009 BALTIMORE, MARYLAND 21. Signature o Funeral Ser .D. HIBNER<sup>22. Name and Address of Facility</sup>PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Par . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirth, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed e Cause (Final diseas or condition resulting in death) 2 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 
Inpatient မ 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

Physiclan: The law requires that the death certificate be executed and burial Box 68760, attending physician for use as the buria signed by the ad be detached to P.O. Division of Vital Records, peen cate has page 2 s certificate After this the Hospital or Attending death. Director: within 24 hours after filled in To the Funeral

death with the Maryland

filed within 72 hours after (Hygiene.

8

Baltimore, Maryland 21215-0036

28a-f show

ŏ items 23a

'natural", or

Health and Mental Hygiene.

item 27

Medical Certification:

29a. Certifier (Check only one) 29b. Signature and title of cer

INGTON

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Year) 31. Date filed (Month, Day,

32. legistrar's Signatu

and manner stated.

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 230AM Arthur Richard Walter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Randallstown Season's Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov.17,1929 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1₺M 2□ F Hours 79<sup>Yrs.</sup> NY 093-24-3655 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location nd 2 should be filed within 72 hours after death with the Marylan Ith and Mertal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Marileal Faminer must be notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Columbia MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21044 5495 Cedar Lane, Apt. 712 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. white Ş 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Clinical Lab. Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Buckingham es 1 and 2 should b of Health and Menta fitem 27 is marked r other traumatic e Arthur Walter ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9361 Breamore Ct., Laurel, MD 20723 C. Megan Larko/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2009 Odenton, MD West Arundel Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. J. Ken Skil M01053 313 Talbott Ave., Laurel, MD 20707 23a. Ph.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached f □Yes 2□No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2. No certificate 1 ☐ Yes 2 No 1 ☐ Yes al or Attending Physician: 7 s after death.
Il Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other Specify 170 SPICE Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral D 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1445931 cause of death (Item 23a) (Type, Print) 2835 Smith Avo Suite 203 Baltimore MD 31. Date file State

Registrar

P.O. Box 68760, X Division of Vital Records. within 24 hours a

To the Funeral L the Hospital

Saltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

De monte de la

Michael Baako, M.D

29c. License number

7300 Van Dusen Road Laurel, Maryland

D0057216

29d. Date signed (Month, Day, Year)

20707

APR 25, 2009

and manner stated.

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATTENDING

PHYSICIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 19a, per Fh. 9891 5/6/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician 743 AM Patricia Anne Winter /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bahimar Franklin Square HOSPHO 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Maryland Under I Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/13/1943 Age (In yrs. last birthday **Funeral** Days Hours Min. Months 1 □ M 2 💆 F Director 65 218-42-6223 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a State ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Experiment near the retified at 1 ☐ Yes 2 X No Director MD Baltimore Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 4 Randell Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: <u>۾</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Chamber of Commerce 12 Executive Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maybelle Gibson ပ Roy C. Lillis 19a. Informant's Name/Relationship (Type. Print)
Remmey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and : Department of Health Important: If item 27 any Injury or other tra once. 21128 C. Richard Renney 4 Randell Avenue - Perry Hall, Maryland (husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 05/04/2009 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signatule of Funeral Service Licenses 11750 Belair Road - Kingsville, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cancer MHM Brain me **Physician** 10 WHUZ disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending pr IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 2 🗌 No 3 Probably Completed peen , 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has director, page 2 s 2 No 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Marrier of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 7009 170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Baltmar, MD 21237 Registrar's Signature 31. Date filed (Month, Day, State MAY 0 6 2009 Registrar

DHMH 17 Rev 1/2001

To the Hospital or within 24 hours at To the Funeral D

WINSOR, LEROY

Registrar DHMH 17 Rev 1/2001 29a, Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Quillbrone Jes Giong ver, MO

GUILLERMO JOSÉ GIANGRECO

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

41F£3000

301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061

29d. Date signed (Month, Day, Year)

MA41, 2009

Registrar

State

3023

32 Registrar's Signat

Fastern Arenne Boltimore MD 21224

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

JC JOHAN

			1- For Amend Item 28 Type of Maryland 15903/09 The Health and Mental Hygiene Certificate of Death Reg. No. 2009   4609
	Physici		1. Decedent's Name (First, Middle, Last)  Patricia Watkins  2. Date of Death Month Day Year April 22 2009 0934 M
· ver	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
-	Funeral		7844 Fernhill Road Pasadena  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
в	Director		214-84-0602  1 M 2 F 49  Yrs. Months Days Hours Min. (Month, Day, Year)  Jan 11, 1960  Maryland
	yland 10w		Usual Residence of Decedent  10a. State
	Ba-f sh	Director	MD Anne Arundel Pasadena 1□Yes 2⊠No
	with the		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  7844 Fernhill Road 21122 U.S.A.
	ems 2:	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It has them 27 is marked other than "natural", or items 23a or 28a-f show if there 27 is marked other than "natural", or items 23a or 28a-f show of other traumatic event, it is final feature from that the institled at	by Fu	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give 3 □ Widowed 4 □ Divorced  1 □ Yes 2 ☑ No Specify: Specify: Specify: White
5-0036	2 should be filed within 72 hours: and Mental Hygiene. Is marked other than "natural"; aumatic event, Ire Marica Erra	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working (16b. Kind of Business/Industry (16b. Kind of
2121	within lene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  12 Property Management Real Estate
nd 2	e filed al Hyg I other vent, I	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Maryland	d Ment d Ment marked matic e	2	William E. Skipper Mary Ann Meredith  10 Mailine Addison (Street and Aumber of Burnl (Street Four Foods)
2	1 and 2 st Health an em 27 ls r ther traur		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  7844 Fernhill Avenue Pasadena, MD 21122
ore,	ges 1 a t of He If item or othe		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Baltimore	t. Pa rtmer rtant: njury		4 Donation 5 Other (Specify) Carroll Cremation Ser: 4/27/09 Hampstead, Maryland
Ва	permi Depar Impor any ir		21. Signature of Funeral Service Licensee  22. Name and Address of Facility 11824 Reisterstown Road  ELINE FUNERAL HOME Reisterstown, MD 21136
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death
-	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):
	Examiner		Sequentially list conditions, b.
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C
90,	icate be executed physician and the burial-transit		Train, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):
68760,	fficate to property to the b	edical	d. CEMPRAN.
Box	eath certific attending p for use as t	an/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery in the past 12 months?   1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy   23d. Date of delivery   Month Day Year
0.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown
S, D	res that signed b be deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ord	w requir been s should	eted	1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	: The law cate has page 2 s	Completed	24a. Was an autopsy findings available prior to completion of cause of performed?  1 □ Yes 2 ■ No 1 □ Yes 2 □ No
/ital	certificate ector, pag	BeC	25. Was case referred to medical example? 26. Place of Death (Check only one)
ot	Physi er this c eral dire	ျ	1
ion	ending sath. or: Afte he fune	ation	2 Accident investigation 4/22/9 934 PM 1 Yes 2 No 5 hot 5e
Division	or Att after de Direct	Certification:	3 Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  7844 Fernhill Rd.  Pasadena, MD
7	To the hospital or Attending Physician: and the Funeral Director: After this certification to the Funeral Director: After this certification pletely filled in by the funeral director, to		29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	ro the livithin 2 ro the livithin 2 ro the liximplet	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	, , , ,		Millin Ray on D0054 4/24/9
			30. Name and address of person who completed ause of death (Item 23a) (Type, Print)  William P Janes, mp 695 America 21035
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature

DHMH 17 Rev 1/2001

Wheeler, Timothy

20.00 4/5/48

		Amend Item For Amend Item 1-State Registrar	- 20,281 pe	:r- ше,	Certifica	ate of	Death			Reg. No	200	9 1	46L0
hysicia		1. Decedent's Name (First, Middle, L	ast)						2. Date of Do Month	eath Da	y Ye	ar	me of Death
ledic amin		4a. Facility Name (If not institution, g	ve street and number)		4b <u>. C</u> it	y, Town, o	or Location	of Death	04	4c.	. County of D	<u> </u>	O CALL
			Nottone		\	)a (		ore				2011	
			Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. las 51	Yrs. Month	er 1 Year S Days	If Under Hours	Min.	8. Date of Bi (Month, D	ay, Year)	958	Birthplace (S Country) MI	State or Foreign
		Usual Residence of Decedent			Town or Location				071116 2		750		ide City Limits
	ŗ			,									Yes 2 No
	Director	MD 10e. Street and Number		BALT	IMORE 10f. Z	Zip Code				10g. Cit	tizen of What	Country?	
	ral	1202 WILCOX ST.	-			202				USA			
	y Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 \( \subseteq Yes \) 2 \( \subsete S \) If Yes, Give			edent of Fooding Cub	an, Mexicar	n, Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - A Black, W Specify: B	hite, etc.	an,
	ed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's I	Year or Dates:		   16a. Decedent's Us	sual Occur	nation			16h K	and of Busine		
	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5		(Give kind of v life. DO NOT	vork done	durina mos	t of workin	g			,	
I		12TH			BARBER				/E1		ELF		
	Be C	17. Father's Name (First, Middle, Las						er's Name MILL	(First, Middle	e, Maiden	Surname)		
ı	은	MARTIN J. YORK,  19a. Informant's Name/Relationship			19b. Mailing Addre	ss (Street				ber, City	or Town, Stat	e, Zip Code)	
l		DONNA GILLIAM/SI	STER		1022 LAF	KEMON	T RD.	, CAI	ONSVII	LE,	MD 21	228	
		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 I	Removal from State	20b. Plac	e of Disposition (Netery, crematory of	lame of r other pla	· i		ate		ocation City O D		
		4 ☐ Donation 5 ☐ Other (Special Service Lice	- 1	<b>1</b>	TRINITY	and Addre		4/23/			JIMORE		21224
	u	) Asleslew	The said	,							JR. I		1111. 231
ĺ		23a. Pari 1. Enter the dise se, or con shock, or heart faire. List only	nplications that wased one cause ach lir	the death. ne.					7.00			Appro	ximate al Between
ı		Immediate Cause (Final disease or condition resulting in death)	a. Int	acra	rial Hu	mer	hay	۷				Onset	and Death
ı		1	Due to (or as	a consequer	ce of):	citel	8	1550	Clat	ICH			
١	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequer	nce of):	1	- 27	,n	AAU	THE	NER		
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequer	nce of):		(10)	CORO	ELEX MEDIC	AL EVA		-	
			d	a oonooquo.			CERTIFICATI	ON WALLE	Afill				
	Medi	IF FEMALE:										-1	
	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3 🗆 Ectopic	pregnano	су				23d. Date of Month	delivery Day	Year
	nysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	t time of dea	in 5 Li Ottler (	specify/_							
ı	[출	Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the underlying	cause giv	ven in Part I			tobacco Yes 2	use contribut		se of death?
	eted				., .				24a. Was				
	Completed	<del></del>							auto perf	psy form <u>ed</u> ?	deat	h?	dings available in of cause of
	Be C	25. Was case referred to medical examiner?					26. Place	of Death	1 ☐ Yes (Check only		) 1 <u> </u>	Yes 2⊡N	0
		1⊠Yes 2□No			N/Outpatient 3 ☐ I	DOA					6 ☐Other (	Specify)	
-	tion:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending  2 ☑ Accident investigation	28a. Date of Inju (Month, Da	v, Year)	Bb. Time of Injury	28c. Inju Wor	ryat rk? ]Yes 2.K∑l		8d. Describe	how inju	01	mul	(
	Certification: To	3 ☐ Suicide 6 ☐ Could not		ury - At home	s, 5-0 A M e, farm, street, factor Sheet		1165 2/3		8f. Location	*			Number ier King
	Cert	4 ☐ Homicide determined	building, etc	с. (Specity)	sheet				Jr.,B1	vd .	e Marti at Lon	bard S	st.,Balt
	ledical	29a. Certifier (Check only one) 1 Certifying F	hysician: To the best miner: On the basis o and manner sta	f examination	edge, death occurre n and/or investigati	ed at the to on, in my	ime, date a opinion, dea	nd place, a ath occurre	and due to the ad at the time	e cause(s e, date an	s) and manne nd place, and	er as stated. due to the ca	MD ause(s)
	Me	29b. Signature and title of contifier	7 -		2	9c. Licens	se number			29d. Da	ate signed (M	onth, Day, Yo	ear)
		1///	Ph	4510	ian	000	2002	20		4	1-17	-09	
		30 Name and address of person who	completed cause of d		Sa) (Type, Print)	Ct.	B 1:	<i>\</i>	re 1	110	212	4]	
		31. Date filed (Month, Day, Year)	3. Registra			/\	1991	TIME	mc /	<i>/\/</i>		1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03271 James R. Abell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day April 23, 2009 1544 hrs **Medical Examiner** Raymond Abell, Sr. James 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's 22501 Newtown Neck Road Leonardtown 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director Country) Maryland 69 08/09/1939 1X M Yrs 218-38-7846 Usual Residence of Decedent 10d. Inside City Limits 10a. State 0b. County 10c. City, Town or Location or items 23a or 28a-f show must be notified at once. St. Mary's Maryland Leonardtown permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 22501 Newtown Neck Road 20650 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 2 X No Yes White Specify: Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: é 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 U.S. Government 12 Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Combs Abell <u>Elizabeth</u> Agnes Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harry B. Abell/Cousin 22620 Pops Way, California, MD 20619 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 04/29/2009 Leonardtown, MD Donation 5 Other Specify St. Francis Xavier 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle Simons M01206 22955 Hollywood Rd., Leonardtown, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial UNPENDED **AMENDED** Box 68760 23d. Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown the 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 No 3 Probably 4 V Unknown Records, P. Completed has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this ဥ 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Director: death.

Yes 2 X No

Death

Year

No

28f. Location (Street and Number or Rural Route Number, City

April 24, 2009

29d. Date signed (Month, Day, Year)

or Town, State)

Medical

Funeral

the 1

Lo

din 30. Name and address of person who completed cause of death (Item 23a)

Investigation

Could not be

determined

Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

31. Date filed (Month, Day, Year, State APP 9 8 Registrar

a

Accident

Suicide

Homicide 29a. Certifier 1

2 1

29b. Signature and title of certifier

Hal

2

3

one)

Registrar's Signatu

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 56 am 2009 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death Examiner CTEONGES DItal Center If Under 24 Hrs. Birthplace (State or Foreign
 Country) 6. Sex 1 □ M 25 F If Under 1 Year In yrs. last birthday, Date of Birth (Month, Day, **Funeral** (Year) Days Months Director Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 'natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Ne If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Š Specify: Black 3□Widowed 4□Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic constitutions. Nanage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State 1 2 9 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signalure of Funeral Service Licensee Stan Bell St. and Winona Morrissette Tohnson Temple Hills hur willicountle Approximate Interval Between 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☑No 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 9 TUnknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant ponditions contributing to death but not resulting in the underlying cause given in Part I. 2 End Star Deseine 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 1 ☐Yes 2 ☑No 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

P.0. Division of Vital Records, Hospital or Attending Physician:

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title

Medical

RICHARD PALMER 132 & Southern avenu MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mi

DHMH 17 Rev 1/2001

32

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0055120

Luite 310

29c. License number

29d. Date signed (Month, Day, Year)

HPA 21 2009

WAShington DC 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1440 Betty Dean Andrews April 18 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** DORCHESTER CAMBRIDGE HOSPITAL DORCHESTER GENERAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. July 31, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛣 F 218-24-7426 1929 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be natified at Dorchester Cambridge 1 Yes 2 No Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the hopertment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-any lnjury or other traumatic event, the Medical Exemination and any lnjury or other traumatic event, the Medical Exemination of the many longer. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 USA 106 West End Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify þ Specify: white 3 ₩ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) assistant treasurer bank 11 Findrews  $\mathcal{B}_{e}$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roland Floyd Dean Claudie Simmons ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charlotte Booze 5120 North Drive, Cambridge, MD 21613 p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/23/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 21. Signature of funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a cons vue Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

State Registrar 29a, Certifier

29b. Signature and title of certifier

Medical

3359

1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahbuba Akhter, M.D.

32. Recustrar's Signature

31. Date filed (Month, Day, Year)

and manner stated.

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			1 - State Registrar	State of	Marylan		artment of H		Mental Hy	giené Reg. No.	. 0 0 5	14014
	• •		Decedent's Name (First, Middle, La	ist)					2. Date of De	ath	.,	3. Time of Death
	Physicia /Medic		Nina Struthers	Bren	ner				April	. Day . 2	0, 200	9 9:30 a M
	Examin		4e. Fecility Name (If not institution, given	e street and num	ber)		4b. City, Town, or	Location of Death	1	4c.	County of De	ath
į			Springhouse Assi				Bethesd				Montg	
	Funeral			Sex 1□M 2⊠F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. B	inhplece (State or Foreign Country)
h	Director		118-18-2632 Usual Residence of Decedent		91	115.			March 2	23, 1	918 N	ew York
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Many Fresh	tor	Maryland Montgo	merv	В	ethesd	a					1 Yes 2K No
	or 284	Directo	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What C	Country?
	23a c		5101 Ridgefield	Road			20816			Unit	ed Sta	tes
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show ent, If a Medical Exarcit er must be coulfied at	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U ces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S) n, Mexican, Puert	pecify Yes or No o Rican, etc.)	D-	<ol> <li>Race - Am Black, Wh</li> </ol>	
0	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give	•		1 ☐ Yes 21 No	Specify:			Specify: Cau	anaian
21213-0030	hour tural	ed b	15. Decedent's E	Year or Da	165:	16a Dece	dent's Usual Occupa	ation			ind of Busines	
Ò	n na	Completed	(Specify only highest gr	ade completed)	4==5:)	(Give	kind of work done of DO NOT use retired	furing most of work	king	100.10		
7	d with giene.	E o	Elementary/Secondary (0-12)	College (1- 5-		Art	Historia	an		Te	acher	
9	e filed at Hyg othe vent,	Bec	17. Father's Name (First, Middle, Las.	")				18. Mother's Nan	ne (First, Middle	, Maiden	Sumame)	
yiand	Menta Menta arked arked	10 8	William Wood	St	ruthers	1		Mary	Blodg	ut	Grun	trer
Mar	2 sho and is ma		19a. Informant's Name/Relationship			19b. Maili	ng Address (Street a	and Number or Ru	ral Route Numb	er, City o	r Town, State,	Zip Code)
≥ ′.	and ealth m 27 her tr		Paul Bremer / So	on	lant 5	-	Dorset Av	enue; Ch				WATER CONTRACTOR OF THE CONTRA
saitimore,	ges 1 t of H if ite		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 [	Removal from S	state	emetery, crei	sition (Name of natory or other place		Date		ocation - City o	
	tmen tant:		* 4 □ Donation 5 □ Other (Speci		Ft.		1n Cremat		2/2009	Bre	ntwood	, MD
a D	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, if a Medical Expriner must be notified at once.		21. Signature of Funeral Service Lice	nsee			2. Name and Addres 140 Rockvi		Simple Rockv			0852
F	- T		23a. Part1. E-t ir the disease, or con shock, r eart failure. List only	plications that ca	used the deat	h. Do not en	er the mode of dying	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
ď	Physician		Immediate Law e (Final disease or Sondition		ration							Onset and Death
	/Medical		resulting in death)	α.	or as a conseq		III					
	Examiner		Sequentially list conditions,		nagia							_
40	pe tis	Exan iner	rf any, leading to immediate cause. Enter Underlying		or as a conseq	uence of):						
		кап	Cause (Diseese or injury that initiated events resulting in death) Last	c. Demen	ntia oras a conseq	uence of):						12 years
8/90,	icate be execule physician and s the burial-trans	alE		000 (0 (	37 43 4 GOIIGOQ	do1108 01).						
200	certificate be execunding physician and use as the burial-trans	edical	•	d								
COX	leath certific attending p I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo							23d. Date of d	elivery
Ď	death	ician/M	in the past 12 months?	4□Pregna	rth 2 ∏Feta ant at time of d		JEctopic pregnancy Other (specify)				Month	Day Year
Ċ.	the	Physic	9 🗆 Unknown	9□ Unkno	WΠ				115 0 100			
S,	w requires that the s been signed by th should be detache	by P	Part II. Other significant conditions	contributing to de	ath but not res	utting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco u	use contribute	to the cause of death?
ecoras	equire en si	ted	Hypertension						1 🗆	Yes 2	<u>Ā</u> No 3□I	Probably 4 Unknown
	as b	Completed							24a. Was	PSY		autopsy findings available completion of cause of
_	T afte	Con							perfe 1 ☐ Yes	ormed? 2X No	death?	es 2 No
VII	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	one)	Δ	
5	Physics Ithis	2	1 Yes 2 No			ER/Outpaties						ssisted Living
	After Une	ion	27. Manner of Death 1 Natural 5 Pending		n, Day Year)	28b. Time o Injury	Work	/at <br Yes 2 □No	28d. Describe	now injur	y occurred	
UNISION	Attending r death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not I	oe ge Place	of Injury - At h	ome farm st	reet, factory, office	165 2 1140	28f Location /	(Street an	ad Number or i	Rural Route Number,
<u> </u>	after d Direct	Certification:	4 Homicide determined	buildin	g, etc. (Specif	(y)	oot, ractory, omos		City or To			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t		29a. Certifier 1 Certifying P	hysician: To the	best of my kno	wiedge, deat	h occurred at the tim	ne, date and place	, and due to the	cause(s)	and manner	as stated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Exa	miner: On the ba and mann	sis of examina er stated.	ation and/or in	vestigation, in my or	oinion, death occu	irred at the time,	, date and	d place, and de	ue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				29c. License	e number		29d. Da	te signed (Mo	nth, Day, Year)
	3		/m/			1	D355	79		04/2	20/2009	)
			30. Name and address of person who									
			Susan J. Miller,	of D	winter de Cinne		in Avenue	#305; B	Bethesda	, MD	20814	
	Sta Registr		APR 22 20	09 /	egistrar's Signa	Some	Mad					
	3.5%		180 94 1010 200	- Julian	- 1-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1- State Registrar TCHD, 04/20/2009, TLS Certificate of Death Amended, #26. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** APRIL 2009 0819 AM CHARLES EDWARD BALL SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT 30473 GENE GIBSON RD. EASTON Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Hours Months Days 1 **XX** 2 □ F 78 220-26-1109 Director SEPT. 4, 1930 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show items 23a or 28a-f share reast be notified Director TALBOT EASTON 1 ☐ Yes XXNo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 30473 GENE GIBSON RD. 21601 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
XXYes 2 □ No
IfYes, Give
Year or Dates: 1947-51 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married ed other than "natural", or i Maryland 21215-0036 1 ☐Yes XXNo WHITE Specify Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRANSPORTATION s 1 and 2 should be filed wind thealth and Mental Hygier item 27 is marked other the other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TILGHMAN H. BALL DOROTHY WATTS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 ar nent of Hear nt: If item 27 30473 GENE GIBSON RD. KATHRYN M. BALL WIFE EASTON, MD 21601 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Usurial 2 Cremation 3 Removal from State permit. Page:
Department o
Important: If
any Injury or
once. 4 Donation 5 Dother (Specify) FAIRVIEW CEMETERY 4-22-2009 CORDOVA, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 S. HARRISON ST. EASTON, MD 21601 21. Signature of Funeral Service Licensee HOME, P.A. MERCEROR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -ndo carditis **Physician** 21Vanth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trag Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ≥ Mitral 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an andiomyof autopsy perform eakemia 1 ☐Yes 2☐No 1 🗆 Yes 2 □ No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 21 HV0 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death neral Director: / filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated within 2 To the I 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

TLS 5+VA

> State Registrar

31. Date filed (Month, Day, Year) APR 2 0 2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signature

A. America

200

M.D 21601

Physician	te of Death onth Da ril 19, 2	ay Year	0 T (D (
Marie Parks Betsock   April   Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death	ril 19, 2	ay Icai	3. Time of Death
Cin		2009 c. County of Death	11:59p <sup>M</sup>
MIGEL S GALGEII		Montgomery	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. 8. Da Months Days Hours Min. (M	te of Birth onth, Day, Year, ber 16, 1	9. Birthpla	ace (State or Foreign ry) WV
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10	d. Inside City Limits
Washington			1 ☐ Yes 2 <b>XX</b> No
Washington  106. Street and Number  107. Zip Code	10g. Ci	itizen of What Count	ry?
3900 Garrison Street NW 20016		USA	
10a. State 10b. County 10c. City, Town or Location  Washington  10a. State 10b. County 10c. City, Town or Location  Washington  11c. Zip Code  11d. Was Decedent of Hispanic Origin? (Specify Year or Dates)  11d. W	es or No- etc.)	14. Race - America Black, White, e Specify: Whit	tc.
1   Yes   1	16b. k	Kind of Business/Indu	ustry
		n Surname)	
17. Father's Name (First, Middle, Last)  David William Parks  18. Mother's Name (First Effic Gertry 194   19			Code)
20a. Method of Disposition    Complete   Com		Location - City or Tow lver Spring,	
Table 1	l Home In	nc. Spring, MD	20901
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respond to the clause (Final disease or condition resulting in death)  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respond to the cause (Final disease or condition resulting in death)  Atrial Fibrillation  Due to (or as a consequence of):	iratory arrest,		Approximate Interval Between Onset and Death
Examiner			
Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury  Hypertension			
Due to (or as a consequence of):    Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):    Due to (or as a consequence of):			
agate be agate be			
IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 1 Pregnant of death 5 Other (media)	_	23d. Date of deliver Month	y Day Year
S & S S S S S S S S S S S S S S S S S S		use contribute to the	
The law the has a sage 2 and 2	fa. Was an autopsy performed? ☐ Yes 2 <b>X</b> No	prior to com	sy findings available ipletion of cause of
25. Was case referred to medical examiner?  1   Yes   2   X  No			
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury 28d. Date of Injury 28b. Time of 28c. Injury at 28d. Date of Injury 28b. Time of 28c. Injury at 28d. Date of Injury 28b. Time of 28c. Injury at 28d. Date of Injury 28d. Date of Inju	Residence escribe how inju		)
The part of the pa	cation (Street a ty or Town, Stat	and Number or Rural te)	Route Number,
29a. Certifier (Check only (Ch	e to the cause(s	(s) and manner as sta	ated. the cause(s)
The state of the s		ate signed (Month, E	
D30247		ril 20, 2009	-
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Alan Morrison 5410 Connecticut Ave. NW. Suite 103 Washington DC 20			
Alan Morrison 5410 Connecticut Ave. NW, Suite 103, Washington DC, 20 State 31. Date filed (Month, Day, Year) 432. Registrar's Signature	U15		

**Physician** /Medical **Examiner** law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, attending physician for use as the burial signed by the a icate has been signated by page 2 should b To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate ht completely filled in by the funeral director, page 5 30

Physician

/Medical

Examiner

**Funeral** 

Director

show

ns 23a or 28a-f shormust be notified at

Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or item any injury or other traumatic event, If a Marical Exercities, page.

Pages 1

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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death with the Maryland

	shock, or heart failure. List only	one cause on each line.				Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. CAROUS Jule to (or as a consequence of .	Imonay Colla	Pie		Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, teating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. He particle.  Due to (or as a consequence of).  c. Due to (or as a consequence of):	Encephalopa Metastasa Breast (A	thy		
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
ed by Pr	Part II. Other significant conditions of	contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacci	o use contribute to t 2 No 3 □ Pro	he cause of death?
Complete	Fluid &	Overload Disord	lev	24a. Was an autopsy performed 1 Yes 2 144	prior to co	opsy findings available ompletion of cause of
Be (	25. Was case referred to medical		26. Place of Deat	h (Check only one)		
0	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient			6 ☐ Other (Speci	fv)
ation: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how in	jury occurred	
Certification:	3 Suicide 6 Could not b 4 Homicide determined		t, factory, office	28f. Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
Medical	29a. Certifier Check only one) Certifying Physics 2 Medical Example 2	nysician: To the best of my knowledge, death miner: On the basis of examination and/or invo- and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as and place, and due t	stated. to the cause(s)
Ř	29b. Signature and title of certifier	Ligno	29c. License number 0 0 5 2 8 6 5	29d. [	Date signed (Month,	Day, Year) 2009

State

Registrar

Kelson M. Figuro, MD. 12700 Goodloes Promise Dr., Bowie, MD. 20720

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. pars

31. Date filed (Month, Day, Year)

APR 2 3 2009

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OD.	-002	-10

ames Aloysius		er, Jr. 1- For State	State o	f Maryland	•	ment of icate of		d Mental I	Hygiene		201	10	11.61
Physicia		Registrar  1. Decedent's Name (Fi	rst. Middle.Last)		Certin	cale of	Dealli		2. Date of De		201	3. Time of	Death 1
Friysicia Medical Exami	_	James		s Butler	Ir				Month April 23,	Day 2009	Year	1900	ırs
		4a. Facility Name (if not	t institution, give s	street and number)	, 01.	4	b. City, Town, or	Location of Dea	ath	4c	. County of Deat		
		Prince George	s Hospital Ce	nter			Cheverly				rince Georg		
Funeral		5. Social Security Number	per 6. Sex	7. Ag	e (In yrs. last b	oirthday)	If Under 1 Yea		f.o.		DD/YYYY) 9. Bii Co	rthplace (Sta ountry)	te or Foreign
Director		215-11-743	1 1 <u>X</u> N	1 2 F	36	Yrs.	Months Day:	S Hours IN	06/0	5/19	72 Ma	rylan	d
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th the Maryland 23a or 28a-f sho notified at once	Director												
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ath w items	Funeral	1 XXNever Married		Armed Forces?			es, specify Cubar			110-	White, etc.	Trouis II raiding	Didoit
ter de		3 Widowed	4 Divorced	Yes, Give Year	X No	1	Yes 2 X No	specify:			Specify:	Black	
ours af	d by	15. Decedent's Educa		or Dates:	pleted) 16		's Usual Occupa			16b.	Kind of Business		
72 hc	ete	Elementary/Seconda	ary (0-12)	College (1-4 or	5+)	during me	ost of working life	, DO NOT use f	retirea)				
03( vithin ene. Pr tha	Completed	11				Sto	ock Cler	k			Aarons H	Rental	
1215-0036 de filed within 72 hours after fental Hygiene, narked other than "natural", event, the Medical Examiner.		17. Father's Name (Firs							me (First, Middle				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be c	James 19a. Informant's Name/	Aloysius	But1	er, Sr	Malling	Address (Stree	Patric	ia L	ouis	e Mac	ddox_	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	2						B Brigan						
and 2 and 2 lealth item 2	ŀ	James A. B 20a. Method of Disposi	tion		20b. Plac	ce of Dispos	ition (Name of ce		Date	20c.	Location - City of	r Town, Stat	е
nore ages 1 art of H at: If ii		1 X Burial 2		Removal from St	ale	matory or oth	<sub>ler place)</sub> Memorial	Cond /	/20/200	ОТ	oonand+	orm M	D
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	H	4 Donation 5 21. Signature of Funera		e /	of Una	22. N	ame and Address	s of Facility Br	insfiel	d F11	neral Ho	ome. P	. A .
P. P. P. F.		Kyle Simon	s M012	206	-		22955 Ho	11ywood	Rd., L	eona	rdtown,	MD 20	650
Physician		23a. Part I. Enter the di failure. List only of	sease, or complic	ations that caused	the death. Do	not enter th	ne mode of dying	, such as cardia	c or respiratory	arrest, sh	ock, or heart	Approxit	mate Interval n Onset and
/Medical xaminer		Immediate Cause (Fina	al disease a. N	lultiple Injuries								g .	Death
7.0		or condition resulting in	n death) D	ue to (or as a cons	equence of):								
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60, ate be er hysiciar e burial	Med	IF FEMALE:		23c. If yes, outcome	me of pregnar	ncy				23	Bd. Date of delive	ery	
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Box 68760, s death certificate be the attending physicied for use as the buring burysicied for use as the buring the puring the puri	Sici	1 Yes 2 No 9	Unknown	4 Pregnant at	time of death	5 Ot	her (Specify)			- 1			
the de	Physician/M	Part II. Other significa	nt conditions	contributing to deat	h but not resu	Iting in the u	inderlying cause	given in Part I.	23e. Di	d tobacco	use contribute t	o the cause	of death?
P.O. es that the gned by he detach	þ			•					1 🗌	Yes 2	✔ No 3 Pr	obably 4	Unknown
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cor e law e e has b e 2 sh	E E					-			_  pe	topsy erformed?	death		2 No
Division of Vital Records, P.O. tal or attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		25. Was case referred	to medical				26.Plac	e of Death (Che		es 2	No 1 🗸	165	140
/ita	Be	examiner? 1 ✓ Yes 2	<u> </u>	spital: 1 Inpatio	ent 2 🗸 EF	R/Outpatient		Other	rsing Home 5	Resid	ence 6 Oth	ner:	
n of \ ding Phy After th funeral	2	27. Manner of Death	140	28a. Date of Inju	ury 28	3b. Time of I	njury 28c. Inju	ury at Work?			jury occurred orcycle-fixed	abject co	llicion
ion tendir eath.	Ę	1 Natural 5 2 ✓ Accident	Pending Investigation	Apr 23, 2009	1	552 hrs	1	Yes 2 ✔ No	Operator	OI IIIO	Ji Cycle-lixed	Object co	IIISIOTI
VISI or At fifter d Direct in by	ijij	3 Suicide 6	Could not be	28e Place of Ir	njury - At home	e, farm, stre	et, factory, office	building, etc.	OF TOW	n State)	and Number or I		
Dispital cours a neral I filled	Certification:	4 Homicide	determined	(Specify) Lo					Laurel Gro	ve Road	@ Kavanagh		hanicsville,
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 C	rtifying Physicia	n: To the best of m On the basis of exa	y knowledge, mination and/	death occur	red at the time, o	date and place, on, death occurre	and due to the ded	ause(s) a ate and p	ind manner as st lace, and due to	ated. the cause(s)	,
To the vithing to the	Medical	29b. Signature and title		and manner stated				se number			. Date signed (A		
		0 10 4	10 1	DIO				.M.E.			ril 24, 2009		
0		30. Name and address	of person who co	ompleted cause of	death (Item 23	Ba)							
		Carol Allan, M		t Medical Exa			Street, Baltin	nore, MD 21	201				
	tate	31. Date filed (Month /	R 2 S 200	32. Registra	ar's Signature	ha	del.						
Regis		MEI		A James		7			<del>_</del>				
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			For	e Type or Prin State of Ma	aryland / Dep	partment of H	lealth and N			ble. 9	14619
			State Registrar		Ce	ertificate of l	Death		g. No.		
	Physicia /Medic		1. Decedent's Name (First, Middle, Mathleen Mar					2. Date of Death April 2	2 Pay	2009	3. Time of Death 12:12 PM
	Examin		4a. Facility Name (If not institution, guntan Hospital		ounty	4b. City, Town, or Elkto	Location of Death		4c. County	of Death	
I	Funeral Director				e (In yrs. last birthda 57 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept 2:	Year) 3,1951	9. Birthp Cour New	place (State or Foreign htry) Jersey
			Usual Residence of Decedent								
	how	_	10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
:	Ba-f s	cto	Maryland Cecil		North E		<u></u>	1.0			1 □Yes 2 No
3	0.0	Dire	10e. Street and Number	1		10f. Zip Code	1	10	g. Citizen of \United		-
:	s 23a	eral	227 Fineburg Ro	-1	Ever in II.C. 46	2190 : B. Was Decedent of H		pacify Vas or No-			can Indian,
	item	Funeral Director	11. Marital Status 1 ☐ Never Married 2XXMarried	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 📉		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		k, White,	
5,	ll', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 <b>X</b> No	Specify:		Specify	Whit	:e
5	atura	Completed	15. Decedent's	Education	16a. De	cedent's Usual Occup	ation	ring 1	6b. Kind of B	usiness/In	dustry
1	ie. an "r	nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	i+)	ve kind of work done of DO NOT use retired	d)	arig	0	T	
7	ed wi lygien rer th	ပ်	12		Ho	memaker	40. Mathada Nam	e (First, Middle, M.	Own ]		
	ntal H ed oth	Be	17. Father's Name (First, Middle, La Thomas Lehman	ist)				ne Weave:		10)	
<u> </u>	permit. Pages 1 and 2 should be filed within 72 nouts after death with the maryland Department of Health and Mental Hygiene.  Important: If time IZ 1s marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evanciant into a holling any once.	မ	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iting Address (Street	and Number or Ru	ral Route Number,	City or Town,	State, Zip	o Code)
2 3	ulthar ulthar 27 Is r trau		James Beckley, J			Fineburg 1					21901
֖֓֞֝֞֝֞֞֜֞֝֓֞֝	f Hearitem		20a. Method of Disposition	_		position (Name of rematory or other place		Date 2	0c. Location		own, State
₽,	ry or		1 ☐ Burial 2 <b>反</b> remation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	Mayerda1	e Cremato	ry P20		ewark,		aware
= =	permit. Departm Importa any Inju once.		21. Signature 1150n usi Servi x Li			22. Name and Addre					101001
<u> </u>			Mulle							, Mar	yland21901
\ P	hysician		23a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that cause only one cause on each line a.	the death. Do not one.	enter the mode of dyir	ng, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
<i>-</i>	/Medical Examiner		resulting in death)	Dile to (or as	nconsequence of):	- Woor	$\sqrt{}$				honer
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (of as	a consequence oi).	- Dice	,			-	(OV')
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5	ne de / the a	ysic	1 □Yes 2 ☑No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 □ Other (specify) _					
ŗ	mar r hed by detad	/ Phys	Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use con	tribute to	the cause of death?
cords,	n sign	d by	Chronic B	ack for	1111			1 □ Ye	s 2 No	3☐ Pro	babiy 4 ☐ Unknown
5	s beer	lete	Asthma					24a. Was an		Were aut	opsy findings available
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5 6	ing P	.:io	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ay, Year) Injur	y Wor	rk?	28d. Describe ho	w injury occu	red	
NISIOII :	tendi leath. <b>for:</b> A the fu	cati	2 Accident investiga 3 Suicide 6 Could no	the l	AA1 6		lYes 2□No	Opt Logotion (Cu	and and Miss	har or Du	ml Pouto Number
5	after d Direct Jin by	Certification: To	4 Homicide determin	20t. Flace of In	jury - At home, farm, tc. <i>(Specify)</i>	street, factory, office		City or Town		per or Hui	ral Route Number,
-	to the hospital or Attending Physician: The law requires that the oean certificate within 24 hours after death.  within 24 hours after death.  with the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the I	Medical C	29a. Certifier (Check only only)  1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	of examination and/o	eath occurred at the t r investigation, in my	ime, date and place opinion, death occu	e, and due to the caurred at the time, da	ause(s) and nate and place	nanner as , and due	stated. to the cause(s)
	Nithin To the Compl	Me	29b Signature and fittle of certifier	MMD		29c. Licens	se number	29	od. Date sign	ed (Month	, Day, Year) 2009
	5		30. Name and address of person w								
	$\sim$		John Mulvey, M.	D., 111 Wes	t High St	reet, Elkt	on, Mary	land 219	921		

State Registrar 31. Date filed (Month, Day, Year)

APR 23 2009

Hay so is me

32. Registrar's Signature

09-02993

Gordon Drysdale Broadfoot, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 14620

		- For State Registrar					Certifica	ate of I	Death				F	Reg. No.				
Physicia		Decedent's Nam	e (First, Midd	le,Last)								2.	Date of De Month	ath Day	Y	ear	3. Time of	
dical Examin		Gor	don	D.	Broa	adfoo	t. J	r.					April 14,	2009		201	2205	hrs
		4a. Facility Name (i						41	. City, Tov	vn, or Lo	cation of	Death		40	c. County	y of Death	n	
		Carroll Hosp	oital Cente	er					Westm	inster					Carroll			
Funeral		5. Social Security N	lumber	6. Sex		7. Age (In )	rs. last bir	thday)	If Under	1 Year	If Under	24Hrs.	8. Date of E	Birth (MM	I/DD/YYY		rthplace (Sta	ate or
Director		213-48-			2 F	61	1	V	Months	Days	Hours	Min.	10/	12/	104	Forei	ountry)	_
				X	2 F	0		Yrs.					107	12/	1941		M.M	D
any	-	Usual Residence o 10a, State	10b. County			10c	City, Town	or Locatio	n				-				10d. Insid	e City Limits
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with ms 2.	uneral	11. Marital Status			12. Was De Armed F	cedent Ever	in U.S.		Decedent s, specify				cify Yes or N	<b>1</b> 0-		ce - Amei nite, etc.	rican Indian	, Black,
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5-0 ed wi	اق	17. Father's Name	(First, Middle	e, Last)						18	8.Mother's	Name (	First, Middle	e, Maide	en Surnar	ne)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medist	Be	Gordo	n D.	Bro	adfo	ot, s	Sr.				Car	olv	n Sh	inl	ev.		te, Zip Code	
21 Mer mar		19a. Informant's N					19	9b. Mailing	Address	(Street	and Numb	per or Ru	ıral Route N	lumber,	City or T	own, Stat	te, Zip Code	*)
MD and 2 sho alth and m 27 is aumati	Ė	Linda B	roadf	oot	, wi			339	99 S	chae	efer	Dr	ive.	Har	nost	ead:	Md or Town, Sta	2107
ore, MD 21215-003 set 1 and 2 should be filed within of Health and Member Higgene. If tiens 7 is marked other the traumatic event, the Meg	ı	20a. Method of Dis					20b. Place	of Disposi		e of cem	etery,		Date	200	c. <b>Locat</b> io	n - City c	or Town, Sta	ite
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland Pages I and Mental Hygiene. utt. If item 27 is marked other than "natural", or items 23a or 28a-f show r other traumatic event, the Medic I Examiner must be notified at once.			X Cremation	-	Removal	from State	Carr	oll	Cre	nat:	ion	4/1	9/200	) 9 I	Hamp	ste	ad, 1	Md.
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Physician 'Medical		failure. List o		e on each	n line.												Betwee	en Onset and Death
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687 ertific	an/	23b. Was deceder past 12 month		tne	- D	birth		2 Fe			Ectopic	pregna	ncy		Mont	n	Day	Year
Box 68  e death certil the attending	sic	1 Yes 2	No 9 U	Inknown		gnant at time nown	o deali	5 Ot	her (Spec	ify)								
. 4 .4	ر پر	Part II. Other sig	nificant cond	litions	house.		t not result	ting in the I	ınderivina	cause o	iven in Pa	art I.	23e. D	id tobac	co use c	ontribute	to the cause	e of death?
P.O. s that I gned by e detac	호	Cirrhosis							,,				1	Yes 2	2 No	3 P	robably 4	<b>✓</b> Unknown
ords, P.O w requires that is been signed b should be deta	pa	Cirriosis	or the live	i, Cilio	ilic alcon	ioi use							24a. W	/as an	1 24	4b. Were	autopsy fin	dings available
ord v req s bee shou	ie l												a	utopsy erformed			to completio	n of cause of
eco he law tre has	Completed														No	1 🗸		2 No
tal Re		25. Was case refe	erred to medi	cal					- 2		of Death	(Check	only one)					
of Vital Records, ng Physician: The law require this certificate has been simeral director, page 2 should be	o Be	examiner?	2 No	H	ospital: 1	Inpatient	2 V ER	/Outpatien	3 D	OA	Other4	Nursin	g Home 5	Res	sidence	6 Ot	her:	
of V t Phy ter th	-	27. Manner of De			28a. Da	te of Injury nth, Day,Year)	281	b. Time of	Injury 2	28c. Inju	ry at Work	c?	28d Descr	ibe how	injury oc	curred		
nding th. th. e fun	Certification:	1 🗸 Natural	5 Pe	ending	(Mo	nth, Day,Year)				1 \	Yes 2	No						
Sio Atter deat ector by th	cat	2 Accident		vestigatio	28e P	ace of Injury	/ - At home	farm, stre	et, factory	office b	uilding, e	tc.	28f. Location	on (Stre	et and N	umber or	Rural Route	Number, City
Division tall or Attendium rs after death.	ļ ij	3 Suicide	de	ould not be etermined	e		7111101110	, , , , , , , , , , , ,			3			vn, State				
Spits hours mera y fille		4 Homicide				est of my kr				timo de	ato and al	200 200	due to the	causa/s	) and ma	nner as s	stated	
Division of Vital Fro the Hospital or Attending Physician: whilm 24 hours after deals. To the Fineral Director: After this certific completely filled in by the funeral director.	Medical		Certifying  Medical E	Physicia xaminer:	on: To the t On the bas	iest of my kr is of examin	nowledge, o ation and/o	or investiga	rred at the ation, in my	opinion	i, death o	courred a	at the time, o	date and	place, a	and due to	o the cause	(s)
To the comp	led				and manne	r stated.					e number						Month, Day	
	2	29b. Signature ar	id title of cen	1					230	O.C.						5, 2009		
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15tIVA		Donna M.				t Medical		er 11	Penn	oreet	, Daitim	iore, iv	ID 21201					
S	tate		onth Day Ye	200	0 32	Registrar's	Signature	for.	Kel									
Regis	100	P	11 11 6	<u>, 200</u>	J Kill	nun	14.	Jug un	,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Bounds Esther Jones 2009 4Dri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbur Micomico SalisburiRehabilitation allursing Ctr. If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign B. Date of Birth (Month, Day, Year) 08/23/1919 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days Hours 1 □ M 2**K** F 219-07-7437 89 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County יטיפווו; וו וופוח בעו saarked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Madical Even fine or ust be הגווופס בו e. 1 X Yes 2 □ No Salisbury Director Maryland Wicomico 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21804 USA 110 Carolyn Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🛣 No white Baltimore, Maryland 21215-0036 ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) real estate agent 11 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Florence Hastings Granville H. Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 9206 Lanham-Severn Rd., Lanham, MD 20706 19a. Informant's Name/Relationship (Type. Print)
Christine R. Bounds/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Wicemetery crematery or other place Wicomico Memorial Park 1 → Burial 2 □ Cremation 3 □ Removal from State 4/24/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Horroway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral 21 avid 23a. Part 1. Enter the disease, or complical ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 900 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) 1 ∐Yes 2 ∐No 9 Unknown 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 1 No 1 ∐ Yes 2 🗆 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ⊡4√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Hatural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certification 2

44

State Registrar

William H. Kobins, M. D. 31. Date filed (Month, Day, Year) - 32. degls

30. Name and address of person



who completed cause of death (Item 23a) (Type, Print)

a.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** AM Willard Grafton Bryan Sr 04 29 1:15 2009 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner BALTIMORE VAMEdIOAL BALT MORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) March 27, 1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Yrs. Maryland 85 Director 216-16-5529 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 X Yes 2 □ No Director E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be i 21921 United States 41 Bridgewell Parkway, Apartment 30 Funeral 12. Was Decedent Ever in U.S. Armed Forces? World War 1 by Yes 2 d No II and If Yes, Give Year or Dates: Korea 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Completed by 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Plumbing Licensed Master Plumber and Mental Hygie Is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Bullock George Bryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21921 Willard G. Bryan, Jr./Son 204 Park Circle, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory of Gilpin Manor May 4, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Memorial Park Elkton. MD 22. Name and Address of Facility
Hicks Home for Funerals, 21. Signa ure of Funeral Service Licensee 21921 103 W. Stockton Street, Elkton, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years COPD /Medical Due to (or as a consequence of): Examiner Preumonas Sequentially list conditions, if any, leading to immediate cause. Enter Undert in Cause (Usesase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 robably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has autopsy performed 2 No Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After e Hospital or Attending 24 hours after death. e Funeral Director: After 5 Pending investigation 1 Anatural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ceNeStreet Baltimore MS 21201

State Registrar DHMH 17 Rev 1/2001 Jennifer

31. Date filed (Month, Day, Year)

Guythe

32. Registrar's Signature

	1	State of Maryland / Department of Health and N  State of Maryland / Department of Health and N  Certificate of Death	•	giene Reg. No.2 (	009	1462
Physiciar /Medica	1	Roderick A. Cole	2. Date of De Month 04	18 Pay	2009	3. Time of Death 9:21P
Examine		a. Facility Name (If not institution, give street and number)  Washington Adventist Hospital  S. Social Security Number  579-68-0274  4b. City, Town, or Location of Death  Takoma Park  If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.   Months   Days   Hours   Min.   Months   Min.   Months   Days   Hours   Min.   Months   Days   Min.   Months   M	8. Date of Bir (Month, Da 12/21/1	Mon	tgomer  9. Birthp	lace (State or Foreig
Director show	-	Journal Residence of Decedent  Oa. State 10b. County 10c. City, Town or Location  DC Washington	12/21/1	.950	1	0d. Inside City Limi
h with the Mary 23a or 28a-f sh at he notified a		Oe. Street and Number 10f. Zip Code 20017		10g. Citizen d		
d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.  7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evan her must be notified at To Bo Completed by Europea Disperse.	2	1. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  1 □ Ves 2 ☑ Divorced  1 □ Ves 2 ☑ No If Yes, Give Year or Dates:  1 □ Ves 2 ☑ No Specify:  1 □ Yes 2 ☑ No Specify:	ecify Yes or No Rican, etc.)	Spe		etc. .can ican
ygiene. ygiene. t, the Medical E	analdinos	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2+  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  X-Ray Technician		Medic		dustry
nd 2 should be filed vially and Mental Hygis 27 is marked other r traumatic event, traumatic area 7. B. C.	0	17. Father's Name (First, Middle, Last)  Herman Cole  Betty J.	Kenda1	1		
other	-	1K Burial 2 Cromption 2 Removed from State cemetery, crematory or other place)		ngton,	DC 2	0017 wn, State
permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licersee  22. Name and Address of Facility Mc  7400 Georgia Avenue				
wate be executed by sician and the burial-transit the burial-transit the burial-transit differ a feet of the burial transit the	ğ	shock, or heart failure. List only one cause on each line. Illumediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, a use it is easing to minimize date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	sculer	dise	me	Onset and Death
ed by the attending phy detached for use as the	y sicial pine	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown			Date of delive	ery Day Year
s been signed by should be detac	בֿ <sup>'</sup>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			_	ne cause of death?
certificate has been sector, page 2 should		25. Was case referred to medical 26. Place of Deat	1 □ Yes	osy rmed? 2 140	b. Were auto prior to co death? 1 □Yes	psy findings availa mpletion of cause 2  No
After this funeral dir	2	examiner?    Yes 2   No	ome 5 ☐ Resi 28d. Describe	dence 6 00 how injury occ	curred	(y) al Route Number,
within 24 hours and after death To the Funeral Director: completely filled in by the		29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the red at the time,	cause(s) and date and plac	manner as see, and due to	stated. the cause(s)
Within To the comp		29b. Signature and title of certifier  MD  29c. License number  D D D 6 0 1	00	29d. Date sig		
2	1	10. Name and address of person who completed cause of death (Item 23a) (Type, Print)  3 University 3 to 0  11. Date filed (Month, Day, Year)  APR 22 2009  APR 23 2009		Altu	FO	2090

DHMH 17 Rev 1/2001

	State of Maryland / Department of Health and Mental Hy  1 - State Registrar  Certificate of Death	gierie Reg. No. 2009 14624
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Norma  Cohen  2. Date of De Month April 1	Day Year 2.25 n.u.
Examiner	4a. Facility Name (If not institution, give street and number)  Shady Grove Adventist Hospital  4b. City, Town, or Location of Death Rockville	4c. County of Death Montgomery
Funeral Director	5. Social Security Number  128-26-7719  1 M 2 X F  7. Age (In yrs. last birthday) 8. Days Hours Min. 9. Jan. 9	9. Birthplace (State or Foreign New York
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middeal Eventine result to retified at once.  To Be Completed by Funeral Director	3 □ Widowed 4 □ Divorced	Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Retail Dept. Stores  Maiden Surname)  on  ser, City or Town, State, Zip Code) 21. Gaithersburg, Md.  20c. Location - City or Town, State  Falls Church, Virginia
dearn certificate be executed  e attending physician and d for use as the burial-transit d for use as the serial-transit dictary/Medical Examiner	d	3 Days 1 Year 1 Year 23d. Date of delivery
To the hospital of Attending Physician: The law requires that the death certifing 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending tompletely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification By Physician Physici	Pleural Effusion  24a. Was auto perference to medical examiner? 1   Yes 2 No   Hospital: 1   Inpatient   2   XER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Res	prior to completion of cause of death? 21 No 1 Yes 2 No one) idence 6 Other (Specify) how injury occurred
within 24 hours after the mospital of Atta within 24 hours after the To the Funeral Direct completely filled in by the Medical Certific		29d. Date signed (Month, Day, Year) April 20, 2009

			Please Type or Print in Bla						
	Amen	de.	State of Maryland  State of Maryland  Registrar #25, MD/TCHD,04/17/09 ph.	0-	rtificate of L		Reg.	2000	14625
	Physicia		1. Decedent's Name (First, Middle, Last)  CLIFTON CUMMINGS					Day Year 4 2009	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Death	1
ز	Funeral		MEMORIAL HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year  Months Days	If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Ye.	TALBOT	nplace (State or Foreign
H	Director		219-36-6526 1XXM 2□ F 69 Usual Residence of Decedent	1939	MD				
]	ryland show	_	10a. State 10b. County 10c. City, *	Town or Lo					10d. Inside City Limits 1 □Yes 2 ▼ vo
	28a-f	recto	MD CAROLINE  10e. Street and Number	PREST	ON 10f. Zip Code		10g.	Citizen of What Cor	
7	23a or	Funeral Director	4710 CEDAR PLACE			655		USA	
9500	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If firem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Evacional count to a suffice at once.	by Fune	11. Marital Status  1 □ Never Married  2 ★ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes ★ M No If Yes, Give Year or Dates:	'	Was Decedent of H If Yes, specify Cuba 1 □Yes 2XX	lispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: WH	, etc.
0-612	ithin 72 hou ne. nan "natura Medical E	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. l	DO NOT use retired	during most of working d)		. Kind of Business/l	
כ	Tiled w I Hygiel other th	Be Cor	10 17. Father's Name (First, Middle, Last)	S	SUPERVISOR	18. Mother's Name (	First, Middle, Maid		1
y a	Menta Menta Marked Matic ev	To B	ANDREW CUMMINGS	_		ANNA RIMM			
Mar	nd 2 sn alth and 27 is rr r traurr		19a. Informant's Name/Relationship (Type. Print)  BETTY L. CUMMINGS WIFE		ng Address <i>(Street)</i> CEDAR P	and Number or Rural  LACE PRES	TON, MD		ip Code)
	Fages 1 a nent of He ant: If item iry or othe		1 ☐ Burial 2 ☑ vermation 3 ☐ Removal from State	metery, cřer	sition (Name of matory or other place	ì		Location - City or	
Dage	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee  Seph M. Ostrowski C.F.S.P	20	00 S. HAR	RISON ST.	EASTON,	MD 21601	HOME, P.A.
	hysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death)  a. Due to (r as a consequence)	dia	ter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate interval Between Onset and Death
	ate be executed nysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence		8				
O. DOX 00	or the hospital of Attending Prlysician: The law requires that redeath certificate be eximiting the virtual of the state of certificate has been signed by the attending physician To the Tuneral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	су		23d. Date of de Month	ivery Day Year		
ecords, r	quires trat en signed t	by	Part II. Other significant conditions contributing to death but not resulti	ting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac		o the cause of death?  robably 4 Unknown
Jan Hecc	cate has be page 2 sho	Completed					24a. Was an autopsy performed 1 □ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of
VICAL	ysician s certif director	To Be	25. Was case referred to medical examiner?  Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie	nt 3 🗆 DOA Oth	26. Place of Death ner: 4 ☐ Nursing Hom		e 6 □Other (Spe	ecify)
VISION OF	ath. ath. vr: After thi	ertification: T	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	28b. Time o Injury	of 28c. Injur		8d. Describe how		
חאות :	lo tre Hospital of Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	C	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)				City or Town, S		
	e Hosp 124 hou e Funer letely fil.	edical	29a. Certifier  (Chack only one)  1 Certifying Physician: To the best of my know and manner stated.	/ledge, deal ion and/or ir	th occurred at the ti nvestigation, in my o	ime, date and place, a opinion, death occurre	and due to the caused at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	Vithin To the comp.	Me	29b. Signature and title of certifier		29c. Licens	se number	29d.	Date signed (Mont	
	G		30. Name and address of person who completed cause of death (Item 2 CHR ISTINE GALAN MD 219	23a) (Type, 5, WA	Print)	) ST EA	STON, MT		

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Par Year) 2009

faces

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, $#10c1 - \frac{For}{State}$ , #19a, TCHD, 04/20/2009, TLS Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DOROTHY H. CLINCH 2009 1055 A APRIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON TALBOT WILLIAM HILL MANOR 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Days Months Hours Min. 1 M 2 XX 567-72-5409 93 NOV. 15. 1915 LA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County or 28a-f show 1 XXes 2 □ No must be notified Director **501 DUTCHMANS LANE** EASTON MD TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 USA 23a 501 DUTCHMANS LANE Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2000 No Specify WHITE Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION TEACHER 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental tem 27 is marked o Pages 1 and 2 should be D partment of Health and Menta Important: If Item 27 is marked any Injury or other traumatic events. FAITH EMIEL ပ္ EMIEL HIDALGO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DR. JACK CLINH HUSBAND CLINCH 501 DUTCHMANS LANE EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4-20-2009 4 ☐ Donation 5 ☐ Other (Specify) WHITE ROSE CREMATORIUM YORK, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JOHN R. MERCER Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such 🗯 cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to consequence of) lan resulting in death) Last Due to (or as a conseque Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 3 Ectopic pregnancy Day 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an

or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit Division of Vital Records,

25. Was case referred to medical examiner?

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

1∐Yes 2⊠No

27. Manper of Death

1 🗖 Natural

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

Be Medical Certification: To death.

To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely TLS 0

filled in by

State Registrar

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 □ No 1 ☐ Yes 1 Tes 26. Place of Death (Check only one)

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

М 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month), Day, Year)

2160

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 1751 Ervin Cook April 17 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince George's Prince George's Community Hospital Cheverly g. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7/1/1936 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 □ F Months Days Hours 579-46-1972 72 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or items 23a or 28a-f shov Examiner must be mutilled at 1 X Yes 2 □ No Director Adelphi Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or items 23a or 20783 US 2006 Pelden Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black f Yes, Give Ye ar or Dates: 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 7 Is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Republican National Elementary/Secondary (0-12) College (1-4or 5+) Committee Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unavailable Essie L. Cooke ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 2006 Peldon Road, Adelphi, MD Janet Cook - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 4/22/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name end Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIAC /Medical Due to (or as a consequence of): Examiner Severe NATIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the case the fourier to the completely filled in by the funeral director, page 2 should be detached for the case the fourier to the completely filled in by the funeral director, page 2 should be detached for the case the fourier to the fourier to the case the fourier to the fourier to the case the fourier to the fourier to the case the fourier to the case the fourier to the case the fourier to the fourier to the case Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2)(No 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

Registrar

K. Michael Figaro, MD, 3001 Hospital Drive, Cheverly, MD 31. Date filed (Month, Day, Year) APR 2 3 2009

29b. Signature and title of certifier

32. Registrar's Signature B. park

Marvel Lines

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

(3)

29c. License number

29d. Date signed (Month, Day, Year)

		-	For State Registrar	ite of Maryland	•	rtment of Ho tificate of D			giene Reg. No. 7	0000	11.620	
			Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death	
	Physicia /Medic		BENJAMIN	CHAMP	ION	SR.		APRIL	19	2009	8:33 PM	
	Examin		4a. Facility Name (If not institution, give street			4b. City, Town, or				ounty of Death	anania	
			PRINCE GEORGE'S H	OSPITAL		CHEVE				INCE GEO		
	Funeral		5. Social Security Number 8. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year   Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h Year) 16 101	9. Birthp Cour 1.6 NEUAL	place (State or Foreign htry) RK,NEW JERS	
	Director		/1/-0/-3815	92	115.			SEPI. 2	.0 19.	LO NEWAI	KK, NEW SERB	
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Loc	ation				1	0d. Inside City Limits	
	f sho	ō		CE'S RO	WIE						1 XYes 2 ☐ No	
	the r	Director	MD   PRINCE GEOR	GE 5 DO	W 11	10f. Zip Code			10g. Citize	n of What Cour	ntry?	
	Sa or	Ö	631 STILLWATER PLACE			20	721		US	SA		
	ms 2	Funeral	11 Marital Status 12. W	as Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14	. Race - Americ		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If lead z? is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Marical Eventral must be invithed at the control of the co	þ	Armed Forces?  1 Never Married 2 Married   1 Myes 2 NoARMY   1 Myes 2 NoARMY   1 Norced   1 No Specify:  2 No ARMY   1 No Specify:							Black, White, pecify: BL	ACK	
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פ	al Hy roth vent	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	_		urname)		
<u> </u>	uld b Ment arked artic e	ျာ	RICHARD CHAMPION				VIOLA					
Baltimore, Maryland	ind 2 sho alth and 27 is me er traume		19a. Informant's Name/Relationship (Type. Pr BENJAMIN CHAMPION JR		19b. Mailin	g Address (Street a	ond Number or Ru OD DRIVE	BELTSV	[LLE,	MARYLAN	D 20705	
<u>ē</u> .	is 1 a of He item		20a. Method of Disposition	com	e of Disposetery, cren	sition (Name of natory or other place		Date		ation - City or To		
Ĕ,	Page nent ( int: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov	ROSI	EDALE	CEMETERY	4/2	5/2009		RK,NEW		
= =	mit. Porta		21. Signature 1 Fur eral Servic Licensee		22	. Name and Addres	s of Facility	J. B. JI	ENRIK	S FUNER	AL ROME	
m	8 8 E 8 6		16-		7	474 LANDO	VER ROAD	LANDOV	ER,MA	RYLAND	20785	
i	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  CHRONIC CONGESTIVE HEART FAILURE  Due to (or as a consequence of):  PULMONARY HYPERTENSION  Due to (or as a consequence of):  Cause (Disease or injury that initiated events  Chronic Congestive HEART FAILURE									
58760,	ficate be executed physician and s the burial-transit	edical Examiner	resulting in death) Last Due to (or as a consequence of):									
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5	ding Physician: The n. After this certificate he funeral director, page	o Be	examiner?  1 Yes 2 No	tal: 1 ☐ Inpatient 2 ☐▼EF	R/Outnaties	nt 3 🗆 DOA Oth	0.51	ome 5 ☐ Resi		Other (Spec	ifv)	
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0	ding th.	텵	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	M 1 🗆	Yes 2□No					
Division of Vital Records,	I or Atter after dea Director J in by the	Certification: To	C C Could not be	Be. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Rui	ral Route Number,	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	(Check only 2 Medical Examiner:	n: To the best of my knowl On the basis of examination and manner stated.	edge, deat on and/or ir	h occurred at the tin estigation, in my c	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)	
	To the Ho within 24 P	Me	29b. Signature and title of certifier	TAMA IN		29c. Licens				signed (Month		
	3	I.	Now M	, copole	٠	D281	95		APR	IL ZZ,	2009	
	30		30. Name and address of person who comple DAVID GOORAY M.D.	eted cause of death (Item 2 450 MERCANT	3a) (Type, LLE L	Print) ANE # 217	LARGO,	MARYLAN	D 20	774		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	he as he	al.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 12:04 20 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OF MARYLAND MEDICAL CTR. BALTIMORE UNIV If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1 XM 2 ☐ F 12 1925 Mar Director 209-14-7830 84 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show iner must be mutified at 1 X Yes 2 ☐ No Westminster Director MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with itent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Madies is not in the Madies in the Madies in the Madies is the market of the Madies in the Madies i 21158 USA #218 205 St. Mark Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 1946 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) NASA Aerospace Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie Kehler ျ Walter Carl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) #218 Westminster, MD 21158 205 St. Mark Way Anna Carl/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans 4/29/2009 Owings Mills, MD 4 Donation 5 Dother (Specify) 21. Sunative of Juneral Service Licensee 2PHITETS AFTEN HOME and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intratranial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 □Yes 2 □No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

WJL 12+1 VA

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

M.D. QUEZADA

RESIDENT PHYSICIAN AVAITUT35017454

29c. License number

29d. Date signed (Month, Day, Year) APRIL 20.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Green ST Baltimore MD ZIZOI 22

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** 28, B:15 PM <sup>™</sup> Thelma Lucille Clark April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northampton Manor Health Care Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 2, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Year) 1919 **Funeral** Hours Min Mary Land Days 1 □ M 2 🔀 F 89 219-07-9686 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hyglens. Indeportant: If item 2 1s marked other than "ratural" or items 23a or 28a-1 shot any injury or other tranmatic event, It a "bedical Examiner must be notified at XX Yes 2□No Director Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 U.S.A. 720 North East Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify: Specify: White δ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Franklin Norwood Mary Ann Dunn ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7207 Indian Summer Lane, Frederick, MD 21702 Jeffrey A. Clark, Sr., Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery May 2, 2009 MD Frederick, 4 Donation 5 Other (Specify) 21. Sign ware on uneral Service of enser <sup>22</sup> Name and Address of Eacility
Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): law requires that the death certificate be executed that initiated events resulting in death) Last and as the burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 □No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director; A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number April 29, 2009

State Registrar 30. Name and address of person w

DHMH 17 Rev 1/2001

JY

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Of F State Registrar	,	artment of Health and rtificate of Death	i Workar Fry	Reg. No. 7 7 9	14632
	Physicia	ın	1. Decedent's Name (First, Middle, Last)  Sylvia Ruth Carey			2. Date of De Month	Day Year	3. Time of Death
-	/Medic Examin	er	4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or Location of De		4c. County of Dea	th .
				Age (In yrs. last birthday)	If Under 1 Year   If Under 24 H Months Days Hours Mi	rs. 8. Date of Bi	rth 9. Bir	thplace (State or Foreign
	Director		215-76-6547 1	64 Yrs.	World S Days 110013	04/27/		laryland
	aryland show	_	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits 1 XYes 2 No
:	r 28a-f	irecto	Maryland Wicomico  10e. Street and Number	Fruitlan	10f. Zip Code		10g. Citizen of What Co	
3	sath with s 23a o	Funeral Director	336 Holiday St.	et Ever in II C 12 1	21826	(Specify Yes or N	USA o- 14. Race - Ame	erican Indian
920	be filed within 72 hours after death with the Maryland tal Hygiene. And other than "natural", or items 23a or 28a-f show event, the i-odical Evariene runst to notified at	δ	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Ves 2 □ If Yes, Give  Year or Date	<b>₽</b> No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □Yes 2 ☑ No Specify:	erto Rican, etc.)	Black, Whit	
15-0	in 72 ho "natui	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of v DO NOT use retired)	vorking	16b. Kind of Business	/Industry
212	ed with lygiene. ner thar	Com	Elementary/Secondary (0-12) College (1-40	main	tenance/housekee		departmen	t store
land	ed d	To Be	17. Father's Name (First, Middle, Last) Phillip White		1	a Mae Tar		
_	S a s		19a. Informant's Name/Relationship (Type. Print) Kenneth James Carey/son	19b. Maili <b>26</b> 9	ng Address <i>(Street and Number or</i> 162 Barrington R.	Rural Route Numb	ber, City or Town, State, Salisbury,	MD 21801
<u>e</u>	- I j t		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposers te Springhi Gardens	matory or other place)	Date 21/09	20c. Location - City or Hebron, M	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Liothe	7-100	Name and Address of Facility Holloway Funera 501 Snow Hill F	a., Sall	soury, MD Z	1004
		Ø 1	23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each immediate Cause (Final	iline.	4	diac or respiratory	arrest,	Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition a card	as a consequence of):	29 4.2-90			
	xaminer	er	Sequentially list conditions, if any, leauning to immediate cause. Enter Underlying	at a consequence of).	ocarcina of a	the live		
	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events c.	as a consequence of):				
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		/Med	IF FEMALE: 23c. If yes, outco	me of pregnancy	1-1		23d. Date of de	elivery
O. Box	at the death by the atter tached for u	Physician/M		nt at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
rds, P.	as tha	by	Part II. Other significant conditions contributing to deat	h but not resulting in the u	inderlying cause given in Part I.		tobacco use contribute ]Yes 2 ☐ No 3 ☐ F	to the cause of death?  Probably 4 🗗 Onknown
Division of Vital Records,	ihe faw require te has been si age 2 should b	Completed				per	opsy prior to formed? death?	autopsy findings available completion of cause of
Vital	scertificate ha lirector, page 2	Be C	25. Was case referred to medical examiner?  Hospital:		Othor	Death (Check only	one)	
n of	ding Phys h. After this funeral dir	on: To	27. Manner of Death 28a. Date of	atient 2 ER/Outpatie Injury 28b. Time of Injury	TIL 3 DOA 4 NUISIN		sidence 6 Other (Sp how injury occurred	ecify)
visio	Atten er deat ector: by the	Certification: To	2 Accident investigation	Injury - At home, farm, st etc. (Specify)	M 1 ☐Yes 2 ☐ No reet, factory, office	28f. Location City or To	(Street and Number or Fown, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge, dea	th occurred at the time, date and p	lace, and due to th	ne cause(s) and manner	as stated.
	the Hohin 24 h	Medical	(Check only one) 2 Medical Examiner: On the bas and manne	stated.	-			
	8 4 ₹ 4	_	29b. Signature and title of certifier	i	742995	_	4/20/00	1
	3 mor		30. Name and address of person who completed cause  Brow L. Mc Curcheou	of death (Item 23a) (Type,	29c. License number 242995 Print) 30 AINUS/OC D1.	SANSAI	in mo	
	Sta Registr			istrar's Signature	arke	/	/	

09-03358 Daniel Decker, Sr.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia		Registrar 1. Decedent's Name (First, Middle, Last	2)					Date of Dea     Month	Day	Year	3. Time of Death 1240 hrs
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<u> </u>		4a. Facility Name (if not institution, give		)	4t	c. City, Town, or L		th		County of Dett. Mary's	eaul
		43225 Belvedere Farm Ro				Leonardtown				-	100
	-	Social Security Number     6. Security Number		ge (In yrs. last	birthday)	If Under 1 Year	If Under 24H		rth (MM/I	OD/YYYY) 9.	Birthplace (State or Forei Country)
Funeral		5. Social Security Humber			Yrs.	Months Days	Hours M	in. 10/31/	1962	2 1	Maryland
Director	- 1	220-76-7188	M 2 F	46_	115.			10/32/			
		Usual Residence of Decedent		10c City To	own or Location	on					10d. Inside City Limit
any		10a. State 10b. County									1 Yes 2 X N
nd nd	占	Maryland St. Mary	7's	Holly	ywood	Col Time Conta		<del></del>	10a. Citi	zen of What	Country?
aryla 8a-f	Sct	10e. Street and Number				10f. Zip Code			Ü		
he M	Director	24404 Mount Pleas	sant Road			20636				ted St	ates merican Indian, Black,
vith t s 238 e not	ā	11. Marital Status	12. Was Decede	nt Ever in U.S.	. 13. Was	s Decedent of Hisp es, specify Cuban,	panic Origin? ( Mexican, Pue	Specify Yes or Nerto Rican, etc.)	10-	White, e	
ath y	Funeral	1 Never Married 2 Married	Armed Force	2 X No	1						T T .
i, or	丘	3 Widowed 4 X Divorce	If Yes, Give Year			Yes 2 X No			1.00	Specify:	White
rs afi ural' mine	b	15. Decedent's Education (Specify of	only highest grade o	ompleted)	16a. Deceden	t's Usual Occupations of working life.	ion (Give kind	of work done retired)	16b.	Kind of Busin	less/industry
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5-0036 tled within 73 Hygiene. d other than the Medical	ple	12		1	Carpen	ter			Co	nstruc	ction
Siene Brenner	Į	17. Father's Name (First, Middle, Las	t)					ame (First, Middle		n Surname)	
Z15- be filec ntal Hy rked o	Bec	Charles William		ír.			Sharon	Lou Sum	ner		
212 212 21d be 21d be 31d be 3	일	19a. Informant's Name/Relationship	Type, Print )		19b. Mailing	g Address (Stree	et and Number	or Rural Route N	lumber, (	City or Town,	State, Zip Code)
shou and 7	-	Charles W. Decke		ther	966 P	enn Wood	Court	, Chambe	rsbu	rg, PA	A 1/201
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat		20a, Method of Disposition		20b. P	Place of Dispos rematory or ot	sition (Name of ce	metery,	Date	20c	. Location - C	City or Town, State
of He	1	1 XBurial 2 Cremation 3	Removal from				0	5 /01 /200	0 T a	onardi	town, MD
Page nent ant: or of	1	4 Donation 5 Other Specia	fy:	/ Cha	rles M	Name and Addres	s of Facility	5/01/200	1 Fo	mara1	Home, P.A.
Baltimore, MID 21215-UU35 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitten 27 is marked other than "natural", or items 23a or 28a-f show Important: I fitten 27 is marked other than "natural".	1	21. Signature of Funeral Service Lice	//	->	22.	955 Holl	B:	rinsile:	a ru	dtown	. MD 20650
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	1	or condition resulting in death)	Due to (or as a co	onsequence of	f):						
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E I	or, p		101				100	Check only one)	c Do	aidenne 6	✔ Other: Scene
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of \ing Phy	era	27. Manner of Death	28a. Date	of Injury Day Year)	28b. Time		njury at Work?	Subject	shot s	elf then w	as shot by police
n C	by the funeral director, page	1 Natural 5 Pendii		2009	1138 hrs	1	Yes 2 🗸	NO .			
Sic Atten	by the	2 Accident Invest	igation 28e. Place	e of Injury - At	home, farm, s	treet, factory, offic	e building, etc.	T .		-1	per or Rural Route Number
Division of Vital Records, tal on Attending Physician: The law requirers after clearly.	filled ii	deterr	not be	Single Fa			_	43225 B	elvedere	e Farm Rd.	, Leonardtown, MD
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e Ho			ysician: To the bes niner:On the basis	of examination	and/or invest	igation, in my opir	nion, death occ	curred at the time.	, date an	d place, and	due to the cause(s)
To th withir To th	comp	· Ι	and manner a	tated.		29c. Lic	ense number		- 12	29d. Date sig	ned (Month, Day, Year)
	٦	29b. Signature and title of certifier		1		1	C.M.E.		- 1.	April 27, 2	2009
		Mhu Bi	ane 4 1	118			. O.1VI. L.				
OUNE		30. Name and address of person	who completed cau	se of death (Ite	em 23a)			MD 04004			
		Melissa Brassell, MD	Assistant Me	edical Exam	niner 11	1 Penn Street	t, Baltimore	e, MD 21201			
	Sta	OA Data Stad (14-849/09) Ones	2000 32.	egistrar's Sign		1					
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			1- State of Ma	aryland		rtment of F tificate of			giene Reg. No. 2	009	14635
	*	\$	Decedent's Name (First, Middle, Last)			timodito or i	- Catiri	2. Date of De	ath	.,	3. Time of Death
	Physici /Medi		John Deal					April	21, 2	009 <sup>Year</sup>	11:30 P M
b	Examir		4a. Facility Name (If not institution, give street and number)			4b. City, Town, o	r Location of Death		4c. Cou	nty of Death	
2	F		Fort Washington Health and Rehak 5. Social Security Number 6. Sex 7. Age	Fort Wa	shington If Under 24 Hrs.	8. Date of Bir			Georges place (State or Foreign		
	Funeral Director		266-26-7573 1™XM 2□ F	88	Yrs.	Months Days	Hours Min.	June 2	y, Year)	Cou	th Carolina
	pun »		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Lo	cation					10d. Inside City Limits
	Maryla f shored ed at	or				outon					1 ☐ Yes 2 X No
	r 28a-	Director	NJ Mercer  10e. Street and Number	ire	nton	10f. Zip Code			10g. Citizen	of What Cou	ntry?
	th wit	al D	511 Greenwood Avenue, Apt.	5Q		08609			USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 N S 2 N If Yes, Give Year or Dates: U	lo		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		lace - Americ Black, White, cify: Bla	etc.
5-0	72 ho 'natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	- 1	16a. Deced	lent's Usual Occup	ation during most of work d)	ing	16b. Kind of	Business/In	dustry
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<u>5</u>	il Hygi Other ent, t	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle			<u> </u>
<u>ylar</u>	ould be Menta arked atic ev	To B	Tom Deal				Clara	a Ball			
Maryland	12 sho h and 7 is ma mauma		19a. Informant's Name/Relationship (Type. Print)				and Number or Rui				*
ē,	Healt Healt tem 2		John R. Deal - Son  20a. Method of Disposition	20b. Pla		Sition (Name of natory or other place	Street,	Date Date	20c. Locatio		
Baltimore,	Pages ment of ant: if it		1 ☐ Burial 2 【3 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		erdale	Park Cr	em. 04/2	3/09	River	dale,	MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	)			ss of Facility Bel nch Ave., T				ome, P. A.
ļ.	-		23a. Part . Enter the disease, or complications that caused spock, or heart failure. List only one cause on each line	the death.						20110	Approximate Interval Between
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Ď.	/Medical Examiner		Due to (or as a	a conseque	nce of):						
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68760,	icate be executed physician and s the burial-transit		Due to (or as a	a conseque	nce of):						
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P.O. Box	Attending Physician: The law requires that the death certificate be executed er death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome properties of the past 12 months? 4 □ Pregnant at 12 □ Pregnant at 13 □ Pregnant a	2 ☐ Fetal d	leath 3□	Ectopic pregnancy Other (specify)				Date of deliv Month	ery Day Year
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ord	equire							1 🗆	Yes 2□ No	3 ☐ Pro	bably Unknown
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סר	ding Phys n. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury	у 2	8b. Time of Injury	28c. Injur	y at	28d. Describe			ry)
Sior	tendin eath. or: Af the fur	catio	2 Accident investigation	, cary	injury		Yes 2 □ No				
Division or	ai or Att s after de i Direct d in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of injurbuilding, etc.		e, farm, stre	eet, factory, office		28f. Location ( City or To	Street and Nu wn, State)	mber or Run	al Route Number,
•	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner state.	examinatio	edge, death on and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and place	manner as s ce, and due t	stated. o the cause(s)
•	To the Correction of the Corre	Me	29b. Signature and title of certifier	222		29c. Licens	e number	-	29d. Date sig	ned (Month,	Day, Year)
•	3		30. Name and address of person who completed cause of de				256.29	ton	Ma	-	
ģw.	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 3 2009  Grant A	r's Signatu	ares	,	~	104	, , ,		
	3.5.		MLII & D FACE TO WAR	7							

DHMH 17 Rev 1/2001

Physician /Medical **Examiner** The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, as attending for use as signed by the a certificate has been si rector, page 2 should I Hospital or Attending Physiclan: funeral director, this After within 24 hours after death.

To the Funeral Director: /

Physician

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

the Medical

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iter

item 27 i

permit. Page Department of Important: If any Injury or once.

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Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

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4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee charlesy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner?
1 Yes 2 Be ဥ 27. Manner of Death Medical Certification: "Aletural 2X Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 634 Back Creek Valley Rd., Glengary, West VA 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04-07-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINDSWWOD

State

31. Date filed (Month, Day, Year) MAY 0 5 2009 Registrar



1126 Opal Court HARPISTON, MOSING

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To the

			For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment of rtificate of	Health and f Death		gien 🗗 🗍 🗍	9 14637
Ī	Physicia	an	1. Decedent's Name (First, Middle, Last	Ellis				2. Date of Dea	Day '	3. Time of Death
	/Medic	al	Delaine L.  4a. Facility Name (If not institution, give			4b. City. Town.	or Location of Dea	04 ath	18 200 4c. County o	
	Examin	er	Southern MArylan			Clint			Prince	e Georges
	Funeral Director	-	5. Social Security Number 6. Se		ast birthday) Yrs.	If Under 1 Yea Months Days			y Year)	Birthplace (State or Foreign Country)     VA
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary Fresho	to	MD Charles	W	aldorf					1. Yes 2 □ No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	hat Country?
	s 23a		10536 Beechwood	Drive  12. Was Decedent Ever in U.	C 12.1	2060	L f Hispanic Origin? (	Specify Ves or No	USA 14 Bace	- American Indian,
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examinating recitional angue.	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1	I Yes 2 X N	ıban, Mexican, Pue	orto Rican, etc.)	Black	, White, etc. Black
<u>.</u>	"natura	Completed	15. Decedent's Edi (Specify only highest grad	ucation le completed)	16a. Deced	dent's Usual Occ kind of work don	upation le during most of w red)	rorking	16b. Kind of Bus	iness/Industry
717	l withir liene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		ırity Gu			Census E	Bureau
מומ	al Hyg d othe	Be C	17. Father's Name (First, Middle, Last) Lonnie W. Smith	2 y 1 3 • · ·				ame (First, Middle,	Maiden Sumame	)
Z Z	Ment America	To		0:4	401 14 11		1	Coleman	- O't T O	7:- 0:-4:
<u> </u>	id 2 sh lth and 27 Is n traun		Joseph L. Ellis (1		1		et and Number or F			
Ġ.	of Heal		20a. Method of Disposition	20b. P		sition (Name of matory or other p		Date		City or Town, State
Dallillor	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 4 ☐ Donation 5 ☐ Other (Specify)	Temoval from State   Ca1	eman M	lem. Cem	. 4-29	1.5	Java, VA	
Dall	permit. Departinport any inj		21. Signature of Funeral Service Licens	hall			ress of Facility MA			
	Physician		23a. Pan Denter the disease, or composition or heart failure. List only commediate Cause (Final disease or condition	lications that caused the death one cause on each line.  Upper Gas				ac or respiratory a	rrest,	Approximate Interval Between Onset and Death 8 hours
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Small Bow		structio	on			8 hours
	cuted nd ransit	Examiner	that initiated events	c						
,007	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequ	uence of):					
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O. DOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnar Other (specify)			23d. Date Mon	of delivery th Day Year
cords, r.	The law requires that the ste has been signed by th bage 2 should be detache	by	Part II. Other significant conditions co	entributing to death but not resu	atting in the u	nderlying cause (	given in Part I.			bute to the cause of death? 3 ☐ Probably 4 ☐Unknown
ב ב	The law reate has bee page 2 sho	completed						24a. Was auto perfo 1 Yes	osy pr ormed? de	Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2 ☒ No
	cian: ertifica	Be C	25. Was case referred to medical examiner?	I handala				eath (Check only o	one)	
5	Physician: this certific ral director,	To	1 ☐XYes 2 ☐ No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 🔀	ER/Outpatien		Other: 4 Nursing		dence 6 Othe	
5	nding ath. r: Afte e fune	atlon	1 ☐ Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	W	lork? □ Yes 2 □ No			
	if or Atteracted Director	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str	eet, factory, offic	ee .	28f. Location ( City or To	Street and Numbe wn, State)	or or Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifying Phy (Check only one) 2 Medical Exam	/sician: To the best of my knoiner: On the basis of examinal and manner stated.	wiedge, death tion and/or in	h occurred at the vestigation, in my	time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0-11:00		29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
	5		Zon		UD	D416	599		4/18/200	09
	3		30. Name and address of person who de Edna R. Hill MD	ompleted cause of death (Item 7508 Surrat			n Mn 207	35		
	Sta Registr		31 Date filed (Month, Day, Year)	32. Registrár's Signa	ture	a_ODIIIC	n no 201	<i></i>		
			/	1-17						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04 **Physician** Taliaferro Clarke Eldridge 2009 19 12:05 amM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundle County Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Say 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 577 36 3325 Hours Days 80 1 ★M 2 F Director DC 9-4-1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show MD Prince Georges YYes 2 □ No Upper Marlboro Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 307 Bathurst STREET 20774 US Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Government Printing Ith and Mental Hygiene.

27 is marked other than 'r traumatic event, the Mental Elementary/Secondary (0-12) College (1-4or 5+) 12yrs +3.5 Printer Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Aruthur Eldridge Mayme Clarke 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 307 Bathurst Street Upper Marlboro, MD 20774 Mae Eldridge- Wife item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ⊈ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4-24-2009 | Blandensburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Mame and Address of Facility John T Rhines FUneral Home LLC Juan Smith 2005 12th St NE Washington, DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dancreas **Physician** 10-0 X disease or condition resulting in death) /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Tirector. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 TEctopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 Other (Sp 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Kold #300

Amended Item 29d per Phy. 04/21/2009 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0615 A<sup>M</sup> 20 2009 John William Erb 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center

5. Social Security Number | 6. Sex | 7. Age (In Westminster 8. Date of Birth 8 - 19941 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Funeral 1**⊠** M 2□ F 67 Months Days Hours Min. 220-40-8605 Director MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location r 28a-f show rotified at 10a, State 1 ☐Yes 21 No Director Westminster MD Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and highly or other traumatic event, the Madical Examitrar must be reported. 21158 USA 642 Cherrytown Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No white Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luella Albert Russell Erb 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3541 Halter Rd., Westminster, MD</u> Helen L. Jewell/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 4/22/09 Silver Run, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 17340 PA Little's F.H. 34 Maple Ave. Littlestown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Beath Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of Acute /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Due to (o) as a consequence of) Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 NO 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1. Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 164 Certifying Physician: To the best of my mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day Year) April 20, 2009 29b. Signature and title of certifier 29c. License number WIL ype, Print) 30. Name and address of person who completed o use of death (Kem 23a) 7 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Elmer W. Fisher APRIL 2009 4:15 /Medical 4c. County of Death St. Mary's 4a. Facility Name (If not institution, give street and number)
St. Mary's Hospital 4b. City. Town, or Location of Death Examiner Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 11, 1918 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. MaryPand 1**X** M 2□ F 90 5**79-10-**6252 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c, City, Town or Location show injury or other traumatic event, the Medical Examiner must be notified at Maryland St. Mary's Mechanicsville 1 ☐ Yes 2 No Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20659 United States 40268 Waterview Drive items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2√2 No Specify: þ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hyglene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Press Room Foreman US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evone. Edwin Miller Fisher Annette Perrygo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Brizzi -Daughter 40268 Waterview Drive Mechanicsville, Maryland 20659 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 4/13/2009 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 mald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the as been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page 2 s certificate l Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [3 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation -4.09 UNKNILDA 1 □Yes 2 No ALC, death. within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Hospital or 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) ٩ 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Anthony Thomas, MD

31. Date filed (Month, Day, Year)

P.O.

Box

32. Registrar's Signature

527 Leonardtown, Md 20630

			For State Registrar	e Type or Prir State of Ma		id / Depa		-lealth	and Mental Hy		anna	11.61.1
	Physici /Medi		1. Decedent's Name (First, Middle, Charles Leslie F	•					2. Date of Di Month 04	eath Pay	2009	3. Time of Death 5:35A M
	Examir Funeral Director		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County								tgomer  9. Birthp	lace (State or Foreign
		ctor	Usual Residence of Decedent  10a. State 10b. County  MD Montgor	nery	10c. Cit	ty, Town or Lo			77071		1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Hours after death with the Maryland hours after death with the Maryland tural", or items 23a or 28a-f show all Exemples in unit by notified at	Completed by Funeral Director	10e. Street and Number 15311 Beaver Bro	12. Was Decedent Armed Forces?	Ever in U	S. 13.	10f. Zip Code 20906 Was Decedent of H If Yes, specify Cub	Hispanic Or an, Mexica	igin? (Specify Yes or N n, Puerto Rican, etc.)	Unite	of What Cour d Stat Race - Americ Black, White, (	es Indian, etc.
0 0 0	72 24	pleted by F	1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced  15. Decedent's (Specify only highest	If Yes, Give Year or Dates: Education grade completed)			1 Yes 2 No dent's Usual Occup kind of work done DO NOT use retired	Specify.  pation during mos			Afri Amer Business/Ind	ican
3	partition of e.) Mary iding a fact 15-0030 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any highly or other traumatic event, the Medical Event once.	To Be Com	17. Father's Name (First, Middle, La Arthur Fearing	College (1-4or 5 <b>5+</b> ast)	i+)	i .	n Resourc	es Sp		e, Maiden Surr	Resou	rces
	and 2 shou and 2 shou lealth and M 27 Is main her traumat		19a. Informant's Name/Relationship			14324	Beaker	Ct.,	er or Rural Route Num. Burtonsvil	le, MD	20866	) 
	Dalliniofe,  bermit. Pages 1 ar Department of Hea mportant: If item 3 any Injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe  21. Signature of Funeral Service Li	ecify)		esapeal	osition (Name of matory or other place Cremat	ory	Date 4/24/2009 by McGuire	Beltsv	-	MD
ć	Dan permi Impo any Ir		23a. Part 1 Enter the disease, or coshock, or heart failure. List of	hefre	I the deat		7400 Geor	gia A	venue, NW,	Washin		-
9	Physician /Medical Examiner	ner	shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a.  Due to (or as	ke a conseq	uence of):					7	onset and Death weeks
3	flicate be executed physician and street burial-transit	edical Examiner	that initiated events resulting in death) Last  C									
538	the death cer the attendin	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	⊒ Ectopic pregnand ⊒ Other <i>(specify)</i> _	су			Date of delive Month	Day Year
	law requires the as been signed 2 should be de	ted by F	Part II. Other significant condition Recurrent Pneumo	onia, seizu		-						ne cause of death?
	in: The law rificate has be or, page 2 sh	<b>Comple</b>	Coronary Artery  25. Was case referred to medical	Disease				26 Plan	24a. Wa autr per 1 □ Yes	opsy formed? 2 🔀 No	lb. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2 No
charles	Physician: Physician: or this certific eral director,	To Be	examiner?  1 X Yes 2 No  27. Manner of Death	28a. Date of Inju	irv	ER/Outpatier	III 3 1 BOX	ner: 4□N	ursing Home 5 ☐ Res			(y)
^ (	To the Hospital or Attending Physician: To the Hospital or Attending Physician: Twithin 24 hours after death.  To the Funeral Director: After this certificat completely filled in by the funeral director, page 2007.	Certification: To	1 X Natural 5 ☐ Pending investiga 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could no determin	t be 290 Place of Init	ury - At h	Injury ome, farm, str fy)		rk? ]Yes 2. □	No 28f. Location			al Route Number,
earing	the Hospital hin 24 hours a the Funeral I	Medical (	(Check only 2 Medical E	Physician: To the best xaminer: On the basis of and manner sta	f examina		nvestigation, in my	opinion, de		e, date and pla	ce, and due t	o the cause(s)
	5 Pro	2	29b. Signature and tive of certifie			00.) (T		50117			gned (Month, 17/200	
	Sta	ite_	30. Name and address of person w Dr. Eric J. Par 31. Date filed (Month, Day, Year)	k, 8600 01d	Geo	rgetow	n Road, E	Bethes	da, MD 20	814		
	Registi		APR 22	2009 Sonew	( J	d. A	whil					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Physician FAKHOURI 2 10.00A M ABI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 840 Gunavette Montgomer Silversbring If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) EBANON Days Hours 1**∀**M 2□ F 219-19-9025 68 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 'natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Evandrair must be notified at Montgomero Silverspring 1 ☐ Yes 2 No **Funeral Director** MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2840 Gunarette 20906 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item Many Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Freight Forwarding Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FAKHOURI FAKHOURI ATMEH MOHAMAD ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Way Silverspring MD20906 AKHOURI 2840 Gunarette 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/22/09 rederick AL-Firdaus MemGarden 22. Name and Address of Facility Aden Muslim Funeral 21. Signature of Funeral Service Licenses DSrill ERSY Street Woodbridge VA-22191 23a. Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** weck disease or condition resulting in death) preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Residence 6 Other (Specify) Certification: To 1 Yes 2 XVO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 □Yes 2 □No within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe. MS CRM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21797 Gate Ct Woodbine ma R. Farrell Ellen 31. Date filed (Month, Day, Year)
APR 22 Registrar's Signature State 2009

DHMH 17 Rev 1/2001

Registrar

			4 101	artment of Health and Men	tal Hygier	11114	14643
	Physici	an	Decedent's Name (First, Middle, Last)			Day Yeer	3. Time of Death
	/Medic	al	WILSIE MAE FIDDERMON  4a. Facility Name (If not institution, give street and number)	4b. City. Town, or Location of Death	PRIL 1	5 2009 4c. County of Deatl	4:03 A M
	Examin	ier	PRINCE GEORGE'S HOSPITAL	CHEVERLY	1	PRINCE G	
	Funeral Director		5. Social Security Number 212-56-0895 6. Sex 1 □ M 2 ☑ F 59 1 1 □ M 2 ☑ F 59 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min. (/	Date of Birth Month, Day, Yea PRIL 2		nplace (State or Foreign untry) RYLAND
	and ww		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl	tor	MD PRINCE GEORGE'S LANDO	VER			1 XYes 2 ☐ No
	n the	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Co	untry?
	ath wi	ral	2208 BRIGHTSEAT ROAD # 201	20785		SA	
36	should be filed within 72 hours after death with the Maryland of Mender Hygiene.  marked other than "natural", or lieme 23a or 28a-f ehow marked other than "natural Examinar mails event, the Medical Examinar mails be notified at	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  11. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.)	14. Race - Ame Black, White Specify:	
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Σ	and 2 ealth a n 27 to			BRIGHTSEAT ROAD # 2	_		
ore	ges 1 t of Hi if iter or oth		1 1 XI BURIAL 2 I Cremation 3 I I Hemoval from State	matory or other place)		Location - City or	
Baltimore,	it. Pay		4 Donation 5 Other (Specify) CHURCH C				MARYLAND
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic ev <u>pnce</u> .		18/	7474 LANDOVER ROAD LA	ANDOVER	INS FUNER	20785
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final CORONA DAY ADDITIONAL CORONA DAY A		spiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  CORONARY ARTERY  Due to (or as a consequence of):	DISEASE			
	Examiner		SEPSIS				
	ס ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. DIABETES MELLIT Due to (or as a consequence of):	US TYPE II			
3760,	death certificate be executed e ettending physicien and ad for use as the burial-transit	icai	d. MYOCARDIAL INFA	RCTION			
ox e	eath certifica ettending ph for use as ti	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	W901
.O. Bo	the death y the etter iched for u	Physician/Med		□Ectopic pregnancy □ Other (specify)		Month	Day Year
Records, P.	Physician: The law requires that the de this certificele hes been signed by the e ral director, page 2 should be detached f	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?
Ö	aw require s been si	Completed			24a. Was an	24b. Were au	topsy findings available
m m	hysiclan: The lav nis certificete hes I director, page 2 :	mo.			autopsy performed′ 1 ☐ Yes 2 ₹ 1	? death?	completion of cause of 2K No
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death Ch	neck only one		
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Division of Vital	si or Attending Phy efter death. I Director: After thi d in by the funeral c	Certification;	3 ☐ Suicide  3 ☐ Suicide  4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, s building, etc. (Specify)		Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Mospitel or within 24 hours efter to the Funeral Director to the Funera	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, deal (check only one)  2 Medical Examiner: On the basis of examination and/or in and manner states?				
	To the To the Complet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Mont	(Day, Year)
)	5		· Lalegy	D16273		4/16/	99.
	91		30. Name and address of person who completed cause of death (Item 23a) (Type		D 00=0=	-	
	tek.		31 Date filed (Month Day Veer) 32 Posistrar's Signature	OAD LANDOVER, MARYLAN	20/85		
	Sta Registr		Si. Date filed (Michinity, Day, 1964)  Si. Date filed (Michinity, Day, 1964)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 For State Registrar AMEND#25perMD, 4/23/09, BMW, MoCo Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:45 a  $^{\mathsf{M}}$ 2009 April 20, Elaine J. Gottlieb /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year) 04/13/1934 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. Massachusetts 75 Director 024-26-4320 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show d 2 should be filed within 72 hours after death with the Marylai th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ine Medical Exyminer must be notified at N Yes 2 No Director Maryland | Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20854 IISA 9808 Tibron Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Tyes 2X No. Specify þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Program Coordinator NIDA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any linjury or other traumatic evones. Marilyn Alpert Harold Nannis 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9808 Tibron Court, Potomac, Maryland Susan R. Berg-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns | 04/22/2009 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00564 21. Signature of Funeral Service Licens 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** avou /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a requires that the death certificate be executed Examir exilaxon burial-tran Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò Month Dav Year in the past 12 months? 1 ☐ Yes 2 █ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ned by the a P.0. 9 Unknown signed by t 1 be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 ☐ Yes 2 🙇 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performe this certificate 2 No 1 ☐ Yes Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28c. 28d. Describe how injury occurred After 1 Certification: or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after To the Hospital of within 24 hours at To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AD 0110

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State Registrar 31. Date filed (Month, Day,

Year)

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** April 17 2009 12:10 a Judah Leo Geller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rockville Hebrew Home of Greater Washington Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 X M 2 □ F New York 090-10-6728 95 10/08/13 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1x Yes 2 No Director MD North Bethesda Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 5809 Nicholson Lane #104 20852 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Shoe Store Merchant - Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Geller Raye Kessler ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5809 Nicholson Lane #104 N.Bethesda, MD 20852 Doris Agatston Companion Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Sharon Gardens 4 ☐ Donation 5 ☐ Other (Specify) 4/20/09 Valhalla NY 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service License M00564 Donald tottlemuch 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) PRESSURE ULCER Examiner Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 I Inknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HROSCL EROSIC 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 1 funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: t□Nursing Home 5 □ Residence 6 □Other (Specify) 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Box 687 Ö Records, Division or Vital

or Attending 24 hours after death. filled in by To the Hospital within 24

Medical

State

Registrar

4 Homicide

29a. Certifier

(Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

MONTRESS

OCKVILLE MDZESS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

& SH 31. Date filed (Month, Day, Year)

22

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician A M 30, 2009 April Margaret Louise Gass /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 38125 Louis Thomas Rd. Avenue St. Mary's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 F 75 Yrs. Director 216-32-8701 June 28, 1933 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show injury or other traumatic event, the Medical Evaniner must be notified at 1 ☐ Yes 2X No Directo Maryland St. Mary's Avenue 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Medical Evantics must be none. 38125 Louis Thomas Rd. 20609 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 No 1 ☐ Never Married 2 🕱 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Joseph Alvey Mary Helen Pilkerton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Ann Gass / Daughter 27070 Holly Lane Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State May 5,2009 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery Bushwood, MD 2 Name and Address of Facility Mattingley—Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20 21. re of Fuperal Service Lipense uchae Jardener 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION MYOCARDIAL **Physician** /Medical Due to (or as a consequence of): MONTHS Examiner 1 Schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The remarks after death records the remarks of the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

þ MEMICUS 1 ☐ Yes 2 1 → O 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 I Homicide 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

To the Hospital within 24 hours a To the Funeral I completely filled

State Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5.



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			for State Registrar	State of N	iai yiai				Death		ieritai i i)	Reg. No. 2	009		464
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	Examin		4a. Facility Name (If not institution, g FREDERICK MEMORI					, Town, or ERIC	Location (	of Death			nty of Death ERICK		
	Funeral Director		5. Social Security Number 6 577–70–0941	. Sex 7. A 1 □ M 2 🖾 F	nge (In yrs.	last birthday Yrs.	) If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth lay, Year)	9. Birth Cou	nplace (Sta untry)	ite or Foreign
	show	Ŀ	Usual Residence of Decedent  10a. State 10b. County			y, Town or L	ocation								e City Limits
	h the Ma or 28a-f	Director	MD Frederi 10e. Street and Number	ick	Fre	ederic		ip Code				10g. Citizen	of What Cou		
	ath wit	rai	6652 Jefferson E					703				USA			
2-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Middical Exemirs must be rediffied at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Test 2 Test 1 Test 2 Test	i? ₹No	S. 13.	Was Dece If Yes, sp 1 □Yes		lispanic Or an, Mexicar Specify:		ecify Yes or N Rican, etc.)		Race - Amer Black, White ecify: Wh	ican Indian , etc. ite	,
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and	uld be filed v fenta! Hygie rked other i tic event, in	To Be	17. Father's Name (First, Middle, La Harry Williams C	·							(First, Middle Sedam	e, Maiden Suri	name)		
Mary	d 2 should th and Mer 7 Is marke traumatic	_	19a. Informant's Name/Relationship Frank Goulart	(Type. Print) Son			•	,				ber, City or To		ip Code)	
ה ה	tem 2		20a. Method of Disposition		20b. F	Place of Disp					ate	20c. Location		own, State	<u> </u>
Saltimo	Pages nent of nt: If i		1  Burial 2  Cremation 3 4 Donation 5  Other (Spe		e I	emetery, cre Mary				5-5-	2009	  Maplet	on. I	ดพล	
	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature Funeral Service Lice	censee/								Basford			
0	20 E # 9	1	John U.S		101176	5 1	06 Ea	st C	hurch	Str	eet Fr	ederick		21701	
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	Physician /Medical		disease or condition resulting in death)	a. <u>Massi</u> Due to (or a		uence of):	cere	bral	her	nerr	hope	Due	MDV	48	hrs.
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	ecuted nd transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	c Coumo	edin	ther	apy		[]	Pa	July 2	DW.		481	hrs
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5	ending lath. ath. rr: After ne funer	ation	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☒ Accident investigat		lay, Year)	28b. Time Injury UNKNO	ಸಿಗ್ M	28c. Injur Work 1 ☐	yat ∢? Yes 2 🛣	- 1		n floo			
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	Hospil 24 hour Funera etely fills	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best taminer: On the basis and manner:	of examina	wledge, dea tion and/or i	th occurre	d at the tir n, in my o	me, date a	nd place, ath occurr	and due to the	e cause(s) and , date and pla	manner as	stated.	
	Fo th∉ vithin Fo the comple	Me	29b. Signature and title of certifier				25	oc. License	e number			29d. Date sig	ned (Month	, Day, Yea	r)

State Registrar

DHMH 17 Rev 1/2001

Swami Nathan, MD 198 Thomas Johnson DR. #207 Frederick, MD 21702
31. Date filed (Month, DM AN) 06 2009<sup>2</sup>. Registrar's Signature S. January

Swami Nathan, MD 198 Thomas Johnson DR. #207 Frederick, MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		1 - State Registrar			rtificate of			Reg. No. 200	9 14648
Phys		1. Decedent's Name (First, Middle RUTH ANN HOWET					2. Date of Dea Month APRIL	14 2009	3. Time of Death 915 P M
	dical niner	4a. Facility Name (If not institution			4b. City, Town, o	or Location of Death		4c. County of Dea	
* 1		WILLIAM HILL MA 5. Social Security Number		o (In use last hirthday)	EASTON If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	TALBO3	thplace (State or Foreign
Funer Direct		128–18–3720	1 □ M <b>XX</b> F	ge (In yrs. last birthday) 93 Yrs.	Months Days	Hours Min.	NOV., 18	, Year) 1915	NY
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
Maryla I-f sho	ţ	MD TALE	aOT.	EASTON					1 □ Yes <b>XX</b> No
ith the	Director	10e. Street and Number			10f. Zip Code	•		10g. Citizen of What Co	ountry?
eath w	Funeral	117 PARK LANE	12. Was Decedent	Ever in U.S. 13	2160	Hispanic Origin? (S		USA 14. Race - Amo	erican Indian.
1215-0036 within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show "A doel Eva in writing the second control of the co	-Fun-	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Forces?	<b>X</b> io	If Yes, specify Cub 1 □ Yes 2 <b>X X</b> o	an, Mexican, Puert  Specify:	o Rican, etc.)	Black, Whit	
5-0036 72 hours aff natural", or	ed by	3 <b>XX</b> idowed 4 □ Divorced	Year or Dates:		dent's Usual Occup			16b. Kind of Business	
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a filed with		12	2	ВС	OKKEEPER		(First Middle	BANKING	
and d be fill ental H ced oth	Be	17. Father's Name (First, Middle,  LEVI HIRAM WELI				1	TH MARY	Maiden Surname) SHAW	
Baltimore, Maryland 2121 sermit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important; if Item 27 is marked other than " any Injury or other traumatic event, its "Are	2	19a. Informant's Name/Relations	hip (Type. Print)		ng Address (Street		ural Route Numbe	er, City or Town, State,	Zip Code)
s 1 and of Health		WILLIAM F. SING 20a. Method of Disposition		20b. Place of Dispo			Date Date	20c. Location - City or	Town, State
MOI Pages nent of int; If It		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State pecify)	WOODLAWN		1	7-2009	EASTON, M	D
Baltim permit. Pag Departmen Important; any injury	DCe.	21. Signature of Funeral Service	Licensee	F	Name and Addre	SS of Facility ELFENBETI	N & NEWN	AM FUNERAL	HOME, P.A.
<b>.</b> 2018	a	コロロルス、 23a. Part 1. Enter the disease, or	MERCERO					, MD 21601	Approximate
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/Medica	al	disease or condition resulting in death)		a conse wence of	VEN	eary		7,	WALLE
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executed in and ial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence or,					
<b>50,</b> be executed clan and ourial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):			-		
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BOX 687 eath certificate attending physi for use as the l	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	elivery
I <b>Records, P.O. BG</b> The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Physician/Medica	in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown			☐ Ectopic pregnand ☐ Other (specify) _	су		Month	Day Year
cords, P.O. w requires that the de been signed by the should be detached		Part II. Other significant condition	ons contributing to death t	out not resulting in the u	nderlying cause/giv	ven in Part I.	_ 23e. Did to	obacco use contribute t	to the cause of death?
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								rmed? death? 2☐No 1☐Ye	
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DIV	ertif	4 ☐ Homicide determ	ined building, e	jury - At home, farm, str tc. <i>(Specify)</i>	eet, lactory, office		City or Tox		idiai riodie ivanibei,
DIVISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death. This certific to the Funeral Director: After this certific completely filled in by the funeral director,	ical C		g Physician: To the best Examiner: On the basis	of examination and/or in					
Fo the vithin 2 Fo the somple	Medical	29b. Signature and title of certifie	and manner s	tated.	29c. Licens			29d. Date signed (Mor	oth, Day, Year)
TLS		1	1)0	MD	02	2575	0	4/15/09	
8		30. Name and address of person	who completed cause of	death (Item 23a) (Type,	Print)	2575 ve. Eas	too MI	0 211-01	
	State	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	· ·	U. DU(3)	101), 1011	Jalou	
Regi	strar	APR 2 0 20	109 Senous	B. gart					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Physician April 24, David Primm Harrison 11:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Civista Medical Center La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days November 18, 1946 Washington, DC Months Min. Hours 1 XM 2 ... F 578-64-3302 62 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show Director 1 ☐ Yes A No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 315 Bucknell Circle 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cable Splicer permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other treasment. PEPCO 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Primm F. Harrison Ann R. Przybysz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda P. Harrison/Wife 315 Bucknell Circle, Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 □ Burial 2 KCremation April 30, 3 Removal from State Brinsfield-Echols Crem. Charlotte Hall, MD 4 □ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., al Service Licens MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 un 23a. Part 1. Enter the disease, or complications that caused the shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Else the carry cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.0. 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 s autopsy performed? 2 No 1 ☐ Yes 1 Tyes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: **Hospital or Attending** 1 Natural 5 Pending Injury n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nirmaladevi Jayanthan MD 3328 Old Washington Rd., Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 28 2009 Registrar

Physician /Medical **Examiner** 

burial-transi

Physician/Medical

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Completed

Be

Certification: To

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

Immediate Cause (Final disease or condition resulting in death)

hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Myoca LNFARCTION hr Due to (or as a consequence of)

426 Dover Street, Easton, Md.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

21601

2 No 3 Probably 4 □Unknown

Year

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1□ Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 1 Inpatient

5 Pending investigation

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred

1 🗌 Yes

Date of Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

2 Accident

3 ☐ Suicide

4 Homicide

Natural

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 2009

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

eted cause of death (Item 23a) (Type, Print) NC Rajasingh, M.D.

D. FACC.

DHMH 17 Rev 1/2001

State Registrar

		For State	State of Mar	yland /		rtment of H tificate of L			-	_	200	9 1	1651
		Registrar  1. Decedent's Name (First, Middle, Last)			Cei	lilicate of L	Jeau	,	2. Date of De				of Death
Physicia /Medic		Kathryn Eliza		ison					April	18 <sup>Da</sup>	2009 Year	4:0	00 a. <sup>M</sup>
Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or				4c	. County of Dea		
Pag.		100 Rambler Roa		(1 14	6 1 46 - (c )	Cambr If Under 1 Year		er 24 Hrs.	8. Date of Bir	th	Dorche		to or Foreign
Funeral Director		5. Social Security Number 6. Sec. 121–12–0821	M 2XIE	(In yrs. last 5	Yrs.	Months Days	Hours	Min.	(Month, Da Aug. 2	y, Year)		thplace (State ountry) nnsylv	
D		Usual Residence of Decedent							Aug. Z	/	<i>J25</i> FC		
arylan show d at	ř	10a. State 10b. County MD Dorches		l0c. City, To	own or Lo	cation Camb	rida	re					e City Limits es 2 ☐ No
the M	Director	10e. Street and Number				10f. Zip Code				10g. Cir	tizen of What C	ountry?	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.  The file of the filed within 72 hours after death with the Maryland for the file of		100 Rambler Roa	đ				2161	3			US	A	
ems?	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic O	rigin? (Spe an, Puerto l	cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Wh		
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shoul nd Me mark	ဥ	19a. Informant's Name/Relationship (Ty	pe. Print)	1	19b. Mailir	ng Address (Street a						Zip Code)	
1 and 2 Health a em 27 Is		C. Webster Johnson	husba			Rambler :		Cambr	idge, N		21613		
Pages 1 Pages		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State			sition (Name of natory or other plac			ate		ocation - City o		I.
t. Pag rtment rtant:		4 ☐ Donation 5 ☐ Other (Specify)		Dorc		er Mem. Po			3/09		mbridge	•	
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service Licens	66			700 Locus		111			al Home D 2161		
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the cause on each line	he death. [								Approxii Interval	mate Between nd Death
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hysic this ce	To	1 Yes 2 Yes	Hospital: 1 ☐ Inpatien		/Outpatier		4 [_]				6 ☐Other (Sp	ecify)	
ding F	ion:	27. Manner of Death  1 Accident investigation	28a. Date of Injury (Month, Day		Bb. Time o Injury	Wor	y at k? Yes 2[		28d. Describe	now inj	ury occurred		
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To the Hospital or Attending Physician: The law requires that the death certification is 4 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (		sician: To the best of iner: On the basis of and manner state	examination									se(s)
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Registrar DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 6:08 PM ALVIN L. JONES APRIL 20 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HAVRE DE GRACE **HARFORD** 601 LEWIS STREET If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | MARCH 7, 1952 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1<del>X</del>M 2□F 587-62-2291 57 MISSISSIPPI Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ▼ No MARYLAND HARFORD HAVRE DE GRACE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21 ROCK GLENN ROAD 21078 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1973–79 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐No Specify: BLACK Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) FACILITIES MANAGER FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALEX MCINTYRE BETTY JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERLIE JONES / SPOUSE 21 ROCK GLENN ROAD, HAVRE DE GRACE, MARYLAND 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JAMES UNITED CEM. 04/30/09 HAVRE DE GRACE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. LISA SCOTT FUNERAL HOME, Approximate Interval Between Onset and Death Immediate Cause (Final CORONARYARTERY DISEASE disease or condition resulting in death) Due to (or as a consequence of): ARDIO MY O Se uentially list conditions if any, leading to immediate cause. Ensease or injury ongestive NEART that initiated events resulting in death) Last Due to or as a consequence of) own

**Physician** /Medical **Examiner** certificate be executed

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**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

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Baltimore, Maryland 21215-0036

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in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Yes 2 No 9 Unknown
				Part II. Other significant conditions
				OF Was case referred to medical

Physician/I	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of delivery Month Day Year
by	Part II. Other significant conditions	contributing to death but not resulting in the underly	ring cause given in Part I.		use contribute to the cause of death C□ No 3□ Probably 4 🛣 nkno
Completed				24a. Was an autopsy performed? 1  Yes 2  No	24b. Were autopsy findings avail- prior to completion of cause death? 1 □ Yes 2 □ No
Be (	25. Was case referred to medical		26. Place of Dea	th (Check only one)	
10 1	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3[	DOA Other: 4 Nursing H	ome 5 Residence	6 Dother (Specify) CAR
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	1	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
edical (		hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.			
ž	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)

29b. Signature and title of certifie

30. Name and address of person who complete ause of death (Item 23a) (Type, Print) 6015. UNION AVE HAVRE de GRACE, MB. 21078

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Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Denun S. Sparke

hours after death Hospital 24 hours a

within 2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 0405 M 0 bnald Joyne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAUSBURY HIOOMICO ROGIONAL MEDICAL PENINSULA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1**™** M 2□ F Months Hours 216 70 6465 Director 1960 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It or Medical Examination must be rediffied an once. Yes 2 No Director MD Wicomico 10f. Žip Code 10g. Citizen of What Country' 10e. Street and Number 2180 Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☑Yes 2 ☐ No Black, White, etc 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Blace þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Kinson 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ towar 204 nes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laye MIP 2180 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 turlock 4 Donation 5 Other (Specify) 22. Name and Address of Facility Isabella W Salisbury tuneral Home 23a. Part 1. Ent - III disea shock, or heart failur. or commication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 □Yes 2 □ No 9 Unknown à s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 2 No 2 No 1 ☐ Yes 1 Tyes this certific al director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) Certification: To I 1 XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural within 24 hours after according to the Funeral Director: After a strength of the funeral by the funeral according to the function of the funeral according to the function of the funeral according to the function of the functi 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) U MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar Chris

31. Date filed (Month

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	Examin	er	4a. Facility Name (If not institution, give			,	Location of Death	1	4c. County of Dea	
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	death with the	Funeral Director	14801 Pennfield C	12. Was Decedent		20906 Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	U.S.A. 14. Race - Am	
	or Her	급	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ ! If Yes, Give	No	If Yes, specify Cuba 1 ☐ Yes 2 H No		o Rican, etc.)		
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)	within 24 ho To the Fun completely	Medic	29b. Signature and title of certifier	completed cause of c	death (Item 23a) (Type	29c. Licenso	3 7 <i>0</i> 0		29d. Date signed (Mor	nth, Day, Year)
) (	within 24 hor To the Fun	Medic	29b. Signature and title of certifier	154 A	death (Item 23a) (Type J. ARTIZA ar's Signature	29c. Licenson	3700			nth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 0436 21,2009 Shelley J. Kay 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Suburban Hospital Rethesda 8. Date of Birth (Month, Day, Ye Oct. 11, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Year) Months Hours 1 □ M 2 🔀 F 1951 Washington, DC 57 215-52-5507 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X∐Yes 2 ☐ No Maryland | Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 U.S.A. 4600 Morgan Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2X Married 2 💢 No 1 ∐Yes 21⁄k No White Specify: 3 Widowed 4 Divorced 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ina Friedman Jack Kay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4600 Morgan Drive, Chevy Chase, Maryland 20815 Al Policicchio-Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition H Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gdns | 04/23/2009 | Olney, Maryland 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc.
1170 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Licer M00564 20852 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Asphyxiation 20 m AssivE Homoptysa mmediate disease or condition resulting in death) Due to (or as a consequence of): pergilloma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ung (ancer Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐Yes 2 No Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show ns 23a or 28a-f shorn rust be notified at

th and Mental Hygiene. 7 is marked other than "natural", or items traumatic event, the Medical Examiner or

with

death

filed within 72 hours after

Pages 1 and 2 should be f nent of Health and Mental

Health a

item 27

permit. Pages Department of Important: If it any injury or c

altimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Director

Funeral

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Completed

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Physician/Medical Examiner and burial-tran physician the attending p After this certificate has been signed by the funeral director, page 2 should be detached Certification: To

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Be Completed

Medical

29a. Certifier

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 MNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

-Bist 2340k per ME's office (exaction Division of Vital al or Attending P after death. filled in by the Hospital of thin 24 hours at the Funeral D completely

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertition 29c. License number

1)0068404

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HRISTOPHER ETTIERI, ma 20814 8600 Old Georgetown Road, Bethesda, MD 31. Date filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TITEM#5 per INF, G901, 3/9/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 18 7:18 AM 2009 Sayrika Kamara April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security:Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 10 M 20 F Months Days 78 579-31-<del>1930</del> Nov. 15 1930 Sierra Leone Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1t Yes 2 No Upper Marlboro Maryland Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20774 10611 Campus Way South Sirra Leone 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify SpecifyBlack 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kamara Yari Abdulay Kamara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Koray Kamara/wife 10611 Campus Way South Upper Marlboro, Md. 20774 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State April 20,09Laurel, Maryland Maryland National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3831 Georgia Ave., N. W. 21. Signature of Funeral Service Licensee Latney's Funeral Home Washington, D. C. 20011 #278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final day disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last yérice of): Uso Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1∐Yes 2.XXNo 1 ☐Yes 2 ☒No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1/≦Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit attending p for use as t certificate has been signed by the rector, page 2 should be detached director. this After thi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mangones.

**Physician** 

/Medical

Examiner

Director

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Physician/Medical Examiner

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Certification: To

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

To the

State Registrar 29b. Signature ลูกิฟุ title of certifier

comes

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10 FM William Earl Keese, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICKI CIVISTA PLATE CENTER HARI If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 577-32-4884 November 22,1927 Director Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 X No Completed by Funeral Director Maryland Charles **Mechanicsville** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 9792 North Ryceville Road 20659 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2**X** No Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) International Union id Nental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Elevator Constructors Elevator Constructor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be William Earl Keese, Sr. Anna Virginia Gould Pages 1 and 2 should and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Keese/Wife 9792 North Ryceville Rd., Mechanicsville, MD 20659 Itimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 28, Department of In portant: If ite IX Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Episcopal Cem. 2009 Charlotte Hall, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licenses M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death 23a. r art 1. En or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Immediate Cause (Final **Physician** M. Eve ISEAS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EART GRSTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) to the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ned by the a I □Yes 2 □ No is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe rmedz 2 **IZ N**o 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification; To this 28b. Time of Injury 27. Manner of Death . Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatore and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar

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ORIGINAL

of person who completed cause of death (Item 23a) (Type, Print)

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Year)

31. Date filed (Month, Day,

V

Degistrar's Signature

31 311, 100 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend items 28a,b,f per M.E. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2009 acqueline /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 🛛 F Yrs. 3, 1941 Director Maryland 68 Jan. 216-40-3662 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show 1⊠Yes 2 No MD Talbot Easton Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death withfurent of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or ant: If item 27 is marked other than "natural", or items 123a or ury or other traumatic event, Item Maclical Exemply or other traumatic event, Item Maclical Exemply or other traumatic event, Item Maclical Exemply. USA 113 Third Haven Heights 21601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 1 Mes 2 Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 XNo Specify. þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cashier bowling center 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jack Kemp Evelyn Baynard မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 1 Department of Health Important: If Item 27 1 any Injury or other tra 4301 Lovers Lane, Trappe, MD daughter Tamara J. Kemp 21673 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/25/09 St. Michaels, MD Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 2161/3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PSIS Physician /Medical Due to (or as a consequence of): Examiner Dus to (or as a consequence of): Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical down IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☑No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural s after deau.
ral Director; Aff 5 Pending investigation 1655 p<sub>M</sub> 1 ☐ Yes 2 🐷 No 2 Accident Face down Steps
28f. Location (Street and Number or Rural Route Number 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 113° Third thaven Heights 4 ☐ Homicide astow maryland within 24 hours a To the Funeral C Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

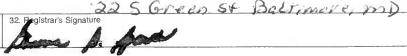
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

erine Sullivan

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 184145918 29d. Date signed (Month, Day, Year)

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			For State Registrar	State of Ma	•		rtment of H			giene <sub>Reg. No.</sub> 2 (	09	14659
			Decedent's Name (First, Middle, Last	)					2. Date of De	ath		3. Time of Death
	Physicia	_	George Kerasid	is					Apr.	22,_2C	Year 09	11:20a M
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	Funeral	1:	5. Social Security Number 6. Se		(In yrs. last birt	thday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	th V Voar)	9. Birth	place (State or Foreign intry)
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	rylan how lat	_	10a. State 10b. County		10c. City, Town	or Loc						10d. Inside City Limits 11☑ Yes 2 ☐ No
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	ems er m	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 14. H	ace - Amer lack, White	ican Indian, , etc.
36	s afte	Y	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X N If Yes, Give	0	1	I∐Yes 2 <b>X</b> No	Specify:		Spec	cify: Ţ	Nhite
8	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	In the second second	Year or Dates:	169	Deced	lent's Usual Occupa	ation		16b. Kind of		
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2	filed Hygi ther		17. Father's Name (First, Middle, Last)	2				18. Mother's Nam		, Maiden Surn	ame)	
Maryland	d be ental ked c	To Be	Harilaos Kerasi	idis				Eleni	Tsolis			
<u> </u>	shoul nd M mar	-	19a. Informant's Name/Relationship (T		19b	. Mailin	g Address (Street a	and Number or Rui	al Route Numb	er, City or Tow	n, State, Z	ip Code)
Š	nd 2 alth a 27 is r trau		Ileana Kerasidi	s/Snouse	. 4:	109	Patuxe	nt Ct.,	Dunki	rk, M	20	754
ē,	s 1 a f Hea f Hea othe		20a. Method of Disposition	•	20b. Place of	Dispo	sition (Name of natory or other plac		Date	20c. Location	n - City or	Town, State
30	Page ento nt: If		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1		ake Cre	i i	3/09	Belts	svill	Le, MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens		Tonest	-	2. Name and Addres		201			, P.A.
m	Dep Imp any		· C. Wor			P	0 Box 4				754	, , , , , , , , , , , , , , , , , , , ,
П	1		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do r							Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Due to (or as a	a consequence	of):						11-010
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a	a consequence	of):						
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Ö,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	a consequence	ot):						
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9	ertific ing p	Mec	IF FEMALE:				200-31	A	-			
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2  Fetal death		Ectopic pregnancy	1			Date of deli Month	ivery Day Y <b>e</b> ar
<u>.</u>	w requires that the death certific been signed by the attending I should be detached for use as	Completed by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 L	Other (specify)	<u></u>				
P.0.	hat th d by letacl	Ph	Part II. Other significant conditions co	ontributing to death bu	ut not resulting in	n the u	nderlying cause give	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
ds,	ires t signe	by	VASCULITIS	_			g,g g-		10	Yes 2	3 □ Pr	obably 4 Unknown
Ö		eted	VASCOCITIO	The state of the s	. //				0.4- 18/		h 18/2-12 21	Anne finding available
%ec	2 5	nple							24a. Was		prior to death?	topsy findings available completion of cause of
a F	cate pag								1□ Yes	2 No	1 ☐ Yes	2 No
Ζij	iclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth	26. Place of Dea				
o	Physiclan: this certificatal director, p	2	1 ☐ Yes 2 ☐ ♣6 ☐	28a. Date of Injur		utpatier Time o	" 3 DOV	4 LI Nursing H	ome 5 ☐ Res	how injury oc		city)
L	After After fune	ion	1 ☑ Natural 5 ☐ Pending	(Month, Day	Year)	Injury	Wor	k? Yes 2 □ No	EGG. GGGGIBG	non injury co		
isi	Attending r death. ector: After oy the fune	icat	3 Suicide 6 Could not be	28e. Place of init	ırv - At home, fa	arm. str	reet, factory, office	100 20.00	28f. Location	(Street and Nu	mber or Ru	ıral Route Number,
Division or Vital Records,	i ji fi o	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)				City or To	own, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			ysician: To the best								
	e Ho 124 h ie Fu	Medical	(Check only 2 ☐ Medical Exan one)	niner: On the basis of and manner sta		nd/or in	vestigation, in my o	opinion, death occu	rred at the time	e, date and pla	ce, and due	e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1)			29c. Licens					h, Day, Year)
			1 / fluis 5	Werel a	3		N. 2	6358		APRI	L 20	2009
	. )		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type,	Print)					,
de	RW 10		150H~ 1-	f. WE	[BP]	1	D-12	PINCE	1-n0	PRICE	, M	1 20677
4	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature							2009
	Regist	rar	APR 2	3 2009 ► 2	Enera	A.	Marked	<i>j</i> .				

			1 - For State Registrar	State of Ma	rylanu / L		tificate of		лентат пу	Reg. N	2 U	09	4560
	Physici	an	1. Decedent's Name (First, Middle, La Angel Lopez-Tremin	•					2. Date of De Month April 1	D	2009	Year	3. Time of Death
	/Medid Examin		4a. Facility Name (If not institution, gi	ve street and number)				r Location of Death	MALL 1	4	c. County o		
	Funeral		Holy Cross Hospita: 5. Social Security Number 6.		(In yrs. last bir	thday)	If Under 1 Year	ver Spring  If Under 24 Hrs.	8. Date of Bi			9. Birthp	lace (State or Foreign
	Director		None Usual Residence of Decedent	1 <b>X</b> M 2□ F	0	Yrs.	Months Days	Hours 15 15	April 18	ay, Yea.	009	Coun	MD MD
vland	how		10a. State 10b. County		10c. City, Town							10	0d. Inside City Limits
he Mai	28a-f s	ecto	MD Prince (	George's	North	bre	ntwood 10f. Zip Code			10= 0	itizon of W	hat Coun	1 □Yes 24 No
h with 1	23a or	al Dir	4506 Banner Street					722		rog. c	Citizen of WI	A Coun	луг
and ZIZI3-UU36 be filed within 72 hours after death with the Marvland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evals in a coust be realthed at once.	by Funeral Director	11. Marital Status  1   Nover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:				lispanic Origin? (Sp an, Mexican, Puerto Specify: Salv		)-		, White, e	
ZIS-UUSD hin 72 hours aft	"natur	leted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Deced (Give k	ent's Usual Occup		ing	16b.	Kind of Bus	siness/Inc	lustry
within	r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	None		d) -			None	e	
yland y	Mental Hyg irked othe itic event,	To Be C	17. Father's Name (First, Middle, Las Anibal Dejesus Lo	•				18. Mother's Name Rocio	e (First, Middle Catherin			·)	
, Mar, and 2 sho	ealth and n 27 is ma her trauma		19a. Informant's Name/Relationship Anibal Lopez / Fat	(Type. Print) <b>her</b>				and Number or Aur et, North B	al Route Numb rentwood				
Dallimore bermit. Pages 1	tment of He tant: If iten jury or oth		20a. Method of Disposition  1		20b. Place of cemeter.  Gate of	f Dispos ry, crem <b>Heav</b>	sition (Name of atory or other place ren Cemeter	y April	Date 22, 2009		ilver S		
<b>Dall</b>	Depart Import any inj		21. Signature & Funeral Service Line	Cerla		22.	Name and Addre Francis J. 500 Univer	ss of Facility Collins Fu sity Blvd.	neral Ho West, Si	me I 1ver	nc. Spring	g, MD	20901
Ph	nysician		23a. Par 1. Enter the disease, or con shock, or hear failure. List only Immediate Cause (Final disease or condition	pplications that caused to one cause on each line <b>Prematur</b>		not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	arrest,			Approximate Interval Between Onset and Death
	Medical kaminer		resulting in death)	Due to (or as a		7 6 6 7 7	brance						
-		ner	Sequentially list conditions, if any reaches to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a	consequence	-	DIGIROS						
xecuted (	and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		of):							
do / do , do / difficate be executed	physician and the burial-transit	/edical E		,	Insuffic	,	<b>y</b>						
A OC	ding pł	/Med	IF FEMALE:	23c. If yes, outcome o	f oregnancy								
Attending Physician: The law requires that the death cer	signed by the attendir I be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	1 Live birth 2 4 Pregnant at 1 9 Unknown	Petal death		Ectopic pregnanc Other (specify)	у			23d. Date Mon		pry Day Year
D, T	signed b	5	Part II. Other significant conditions	contributing to death but	not resulting ir	the un	derlying cause give	en in Part I.					e cause of death?
w requir	has been si ye 2 should b	leted							24a. Was				ably 4 ☐ Unknown  psy findings available
The la	ate has page 2	Completed							auto		10	rior to coreath?	npletion of cause of
VILA ician;	n. After this certificate h funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:		_	Oth	26. Place of Deat					
P Pys	r this eral dir	1: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 X Inpatien	t 2 ER/Ou	tpatient Fime of	3 □ DOA Oth	4 Li Nursing Ho	me 5 Resi				<i>'</i> )
ending	ath. or: Afte he fune	atior	1XXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, n	Year) I	njury	Worl	k? Yes 2 □No		,	,		
tal or Att	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, fa (Specify)	rm, stre	et, factory, office		28f. Location ( City or To			r or Rura	l Route Number,
the Hospi	iin 24 hou Ithe Funer Ipletely fill	Medical	29a. Certifier 1 ✓ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner state	examination an	e, death id/or inv	occurred at the tile estigation, in my c	me, date and place, ppinion, death occur	and due to the red at the time	cause , date a	(s) and mar nd place, a	nner as s nd due to	rated. the cause(s)
To I	To Con	N	29b. Signature and title of certifler	Kn			29c. Licens	e number	0	29d. D	ate signed	(Month, I	Day Year)
_			30. Name and address of person who Ronald D. Jacobs	completed cause of dea 1400 Forest	ath (Item 23a) : <b>Glen R</b> d	(Type, F	oo, Silver	Spring, MD	20910				
	Sta Registr		31. Date filed (Morith, Day, Year)  APR 22 2	009 Sekua	's Signature	pa	Red						

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Jenniter Schmidt

MAY 0 5 2009

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** 1:25 Jacob Robert Lorence 29 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** St. Mary's Hospital St. Marv's Leonardtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Hours 1⊠M 2□ F 70 218-38-6556 Director Maryland August 8, 1938 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show 1 ☐Yes 21 No Director Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23463 Huckleberry Way 20636 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: White Specify ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Technician Telephone 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Jacob James Lorence Mary Lelia Welch ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai once. 23463 Huckleberry Way Patricia Ann Lorence / Wife Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 4, 2009 St. John's Catholic Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and ddress of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No Lead to the runeral unrector. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medical 29a. Certifier 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MOOTCAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20650 HEO DOR Mary's Hospital Leonardtown 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 29 Registrar

DHMH 17 Rev 1/2001

Lorenc

1900 Robert

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day 2009 Physician Emma Musser Linthicum 16, 10:54 a M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Aug 31, 7. Age (In yrs. last birthday, **Funeral** Days Min. 1 □ M 2 X F Hours 218-20-0453 82 Maryland Director 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Musical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Carroll Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6245 Middleburg Road 21757 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: white 3 Widowed 4 □ Divorced Ye ar or Dates. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture/Dairy Farmer should be filt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic enones. Henry Marcellus Musser Mary Elizabeth Gartner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca J. Littrell, daughter 6 Zephyr Court, Taneytown, MD 21787 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 

Burial 2 □ Cremation 3 □ Removal from State St Joseph's Catholic 4/20/2009 Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee R 136 E Baltimore St, Taneytown, MD 21787 intern 23a: Parter Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): LOSTRIDIUM DIFFICILE COLITIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and physician are the burial-t Due to (or as a consequence of) Physician/Medical attending property for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the sid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2**X** No 3 Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t firector, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To . Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. Accident 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

P.O. Box 68760, Division of Vital Records,

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS (\$\frac{1}{200}\$, MD \ \ \frac{200}{200} \textit{memorial AVENUE, WESTMINSTER MD 2115} FRANCIS KHOO, 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

D 30263

4-16-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April 20, Day 2009 Estella Jeanne Miller 7:15a M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 H Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days Hours 1 □ M 2**XX**F 579-14-6566 Yrs June 27, 1921 DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No MD Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 Cardigan Ct. 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 21 No Specify: White 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Lewis Plant Adele Jeannitte Berrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 Cardigan Court, Waldorf, MD 20602 Jeremy R. Snyder / Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery April 24, 2009 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 Appellanchance Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Failure Due to (or as a consequence of): Acute Pulmonary Embolism Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi-Acute Deep Vein Thrombosis Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24a, Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a, State

**Funeral** 

Director

ral", or items 23a or 28a-f show Expedience ust be notified at

"natural", er than "natura The Medical E

other

is marked of

Department of Health and Important: If item 27 is in any injury or other traum once.

Directo

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and the burial-transi Exami Physician/Medical attending pl signed by the a 2 Completed certificate has b funeral director, Be Certification: To s after death.

I Director: A din by the fu

or Attending Physician: The law requires that the death certificate be executed

After this

filled within 24 hours a To the Funeral I completely filled To the Hospital

Medical

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □Yes 2 No 9 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

autopsy 2 X No

1 ☐ Yes

29b. Signature and title of certifier

29c. License number D65305

29d. Date signed (Month, Day, Year) April 20, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nabia Khan M.D. 1500 Forest Glen Road., Silver Spring, MD 20910

31. Date filed (Month, Day, Year) State APR 22

1 X Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only

32 Registrar's Signature



Registrar

		amend	State of	f Marylan	id 7 Depa	artment	of Healt	h and M	1ental Hyg	iene	000	11 /	00
		1 - For State Registrar				rtificate				eg. No.	109	140	00
		1. Decedent's Name (First, Middle, L	ast)						2. Date of Deat Month	h Day	Year	3. Time of D	Death
Physici /Medio		Willie M. N	1cKnight						04	18	2009	2114	+ M
Examir		4a. Facility Name (If not institution, g					wn, or Locati				nty of Death		
<i>k</i>		Washington Adver		-	1	If Under 1	ma Par	K der 24 Hrs.	8. Date of Birth		gomer	y place (State or	Foreign
Funeral Director		5. Social Security Number 6. 578-60-1568	Sex MXXF	7. Age (In yrs. 6.)			Days Hou		July 9,	<sup>Year)</sup> 1947	Cour	hburg,	
		Usual Residence of Decedent							0427 77		1-7		
ryland <b>how</b>	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City  1    Yes   Yes	
e Ma Ba-f s	Director	Maryland Montgon	nery	S	ilver								
vith th	Öİ	10e. Street and Number		. #101		10f. Zip C			1	0g. Citizen o		ntry?	
eath v Is 23e nust	Funeral	1515 November (	<del>-</del>	ot. #104 edent Ever in U	S 13		20904	Origin? (Sp	ecify Yes or No-	U.S.	A . ace - Americ	can Indian.	
ter de iner r	Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	Armed Fo	rces?					ecify Yes or No- Rican, etc.)	В	lack, White,	etc.	
urs af	þ	3 ☐ Widowed 4 🗓 Divorced	If Yes, Giv Year or D	/e		1 □ Yes 2 □	XNo Spe	cify:		Spec	cify: Bla	ack	
72 ho	eted	15. Decedent's (Specify only highest g	Education		1 (Give	dent's Usual (	done durina i	most of work	ina	16b. Kind of	Business/In-	dustry	
ithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use : ninist:	retired)			Priva	te		
led w Hygie her ti		17. Father's Name (First, Middle, Las	2		Acı	ninisti			e (First, Middle,	Maiden Surn	ame)		
d be f ental l ced of	Be c	Frank Le	e JOhnso	on			10.11		Roxie R	ucker	,		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show raumatic event, the Mental Framiner must be notified at	ပ	19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (S	Street and Nu	umber or Rur	al Route Numbe	r, City or Tou	vn, State, Zip	Code)	
alth a 27 is		Anna Miller (Sist	er)		1530	l Pine	0rcha	rd Dri	ive #2F	SIlver	Spri	ng, MD.	.2090
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Merical Examiner must be notified at once.		20a. Method of Disposition	□ Domeual from	20b. F	Place of Disponentery, creamony M	osition (Name	of er place)	4/29/	Date / 2000	20c. Locatio	-		1
Page ment ant: It ury o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State Har	-							aryland	
epart nport ny Inj		21. Signature of Funeral Service Lic	ensee						shall's				
		4 Pman	shall	1.7					.W. Wash		I, D.C	. 2001 Approximate	
		23a. Page 1. En er the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on e	ach line.		ter the mode t	or aying, suc	n as cardiac	or respiratory an	est,		Interval Betw Onset and D	veen
Physician /Medical		disease or condition resulting in death)	d	PSIS							-		
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ecutec nd rransi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	с										
cate be executed cate be executed ohysician and the burial-transit	ĕ	resulting in death) Last	Due to	or as a conseq	quence of):								
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The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, out	come of pregn	ancy			10000		23d.	Date of deliv	erv	
death a atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregi	oirth 2  Feta nant at time of		☐ Ectopic pre					Month	-	'ear
at the deby the detached	hysi	9 Unknown	9 □ Unkn	own					_				
ires tha signed	by P	Part II. Other significant conditions	_		sulting in the u	nderlying cau	ise given in F	Part I.				he cause of de	,
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e law r has be	Completed	END STAGE	RENAL	DIS	SEASE	>			24a. Was a autop	sv 🔺	prior to co	opsy findings a empletion of ca	available ause of
	5	HYPOTENSION							perfor 1 □ Yes	med? 2 No	death? 1 ☐ Yes	2 🖾 No	
Physiclan: r this certific	Be	25. Was case referred to medical examiner?	Hospital:				Othor		th (Check only or				
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<b>_ m</b> oo	ţi	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day, Year) Injury Work?										
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lospit hour unera		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the aminer: On the b	best of my knows	owledge, dear	th occurred at	t the time, da	ate and place	, and due to the	cause(s) and	manner as	stated. to the cause(s)	)
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	one)		ner stated.									
To vitt	Ž	29b. Signature and title of certifier		M.D		290.	License num			29d. Date sig	19	, vay, ical)	
5					00a) (T	Drint	- 311	<u> </u>		1/201	0 '		
31		30. Name and address of person when TASNEEM M.		3/		RROLL	AVE	-NUE	TAICO	HA PH	ARK.	MDS	20917

Registrar

31 Date filed (Month, Day, Year) APR 2 3 2009 DHMH 17 Rev 1/2001

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 17, 2009 10:45AM REBECCA ANN MEREDITH 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) CHARLES NEWBURG 12465 SHILOH CHURCH ROAD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number Months Days Hours 1 □ M 2 🛣 F 90 AUGUST 10, 1918 MARYLAND 216-30-4867 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1X Yes 2 No CHARLES NEWBURG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20664 12465 SHILOH CHURCH ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHERS AIDE EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELIZA EDMONIA FORD WASHINGTON GUY WASHINGTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 418 PATUXENT COURT, LAPLATA, BEVERLY WADE/NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/23/2009 SHILOH CHURCH CEMETERY NEWBURG, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee LYDIA C. THORNTON 22. Name and Address of Facility THORNION FINERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 JOHNSON M00583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2,000 2 $\square$ No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

200

Physician /Medical Examiner

permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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Director

Funeral

Completed by

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Examine physician and s the burial-trans Physician/Medical attending for use as as ed by the signed | ð page 2 should Completed has certificate Be Certification: To this

funeral director After 1

requires that the death certificate be executed Attending To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A filled in by

DB5 State

31. Date filed (Month, Day, Year) APR 2 2 2009

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAYANTHAN, M.D., P.A.

and manner stated.

32. Registrar's Signature Deneur

3328 OLD WASHINGTON ROAD, WALDORF, MD 20602

parke

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 29, Day 2009 Year **Physician** 12:45 PM Karen Mocek-Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 5911 Genesis Lane, Room 309 Fredelick

| Funder 1 Year | Funder 24 Hrs. | 8. Date of Birth (Month, Day, Pear) | Feb. 26, 1953 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 56 049-40-1915 Connecticut Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Frederick 1 ☐ Yes 2 XNo Maryland Frederick Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 6505 Springwater Court, Apt. 7203 21701 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 21√∑No Specify: Specify: White <u>ک</u> 3 Widowed 4 Divorced Be Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mangones. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edmund Mocek Jane Aston ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 2220 W. Palace Green Terrace, Frederick, MD 21702 Miss Sasha Mocek-Jones, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Smithsburg Crematory May 1, 2009 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun, rat Gervice Lice 22. Recenter dodget of Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death yeols mmediate Cause (Final HENOGARCINOMA OF THE BUE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes PMNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Living
6 Other (Specify) this c Hospital: Other: 4 Nursing Home 5 Residence 1 Yes ≩ZÍNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1- Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: A 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature apartitle of certifie 29c. License number 29d. Date signed (Month, Day, Year) D31761 April 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 501 W. SEVENTH ST. FREDERICK MD 21701

State Registrar 31. Date filed (Month, Day, Year)

			State of Maryland / Department of Health and Me	ental Hygie	ene	11.660
			Registrar Certificate of Death	Reg	J. No.	3. Time of Death
	Physici			Month April 29	Day Year	3:55 p.m.
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	APILL 23	4c. County of Deat	
	LAUIIII		47447 South Snow Hill Manor Road St. Mary's City		St. Mary	† s
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Birt	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	Nov. 24	, 1913 Mar	yland
	/land		10a. State 10b. County 10c. City, Town or Location			10d. inside City Limits
	a-f sh	ctor	Maryland St. Mary's St. Mary's City			1 ∐Yes 2 ZKNo
	or 28	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry?
	ath w		47447 South Snow Hill Manor Road 20686		USA	
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show siteal Exeminat to restilled at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced  12. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ring Year or Dates:  13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ring Year or Dates:	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:	
215-003	e hour		15. Decedent's Education 16a, Decedent's Usual Occupation	16	6b. Kind of Business/i	
212	hin 72 8. <b>an "nat</b>	Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)	9		
7	filed within Hygiene. other than '	Com	12 Self Employed		wner/Oper	ator Tavern
g	0 9	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (	(First, Middle, Ma		
<u>\frac{2}{3}</u>	should and Men marke	ပ္	James Bean Daisey		Hebb	
Maryland	d 2 sho th and 17 Is m traum	W S	19a. Informant's Name/Relationship (Type. Print)  Kevin E. Newbold/Son  P.O. Box 365, St. Mar.		-	
	ges 1 and 2 should be t of Health and Menta If item 27 Is marked or other traumatic ev		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date of Disposition (Name of cemetery, crematory or other place)		oc. Location - City or	
altımore,	permit. Pages Department of Important: If it any Injury or o		1⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Holy Face Cemetery  5/04/	2009	Great Mill	s, MD
<u>=</u>	mit. Partm partm portar y Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brin		Funeral Ho	ome, P.A.
ñ	Ber Ber		Kyle Simons M01206 22955 Hollywood Rd.	, Leona:	rdtown, MI	20650
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such an cardiac or shock, or heart failure. List only one cause on each line.	respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition as Terminal Cause)	2		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or a la consequence of):			12 0
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_	certificanding place as t		IF FEMALE:			
X R R	w requires that the death certif : been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		23d. Date of del Month	ivery Day Year
j	y the check	ysic	1 ☐ Yes 2 2 M No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
ν. Τ	requires that the neen signed by th		Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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ecoras,	g 25 C	Completed		24a. Was an	24b. Were au	topsy findings available
Ť	The late has	mo		autopsy performe	ed? death?	completion of cause of
VItal	ding Physician: The law h. After this certificate has b. funeral director, page 2 s.	Be (	25. Was case referred to medical examiner?	(Check only one)		
0	Physical this call dire		1 ☐ Yes 2 ♣ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom			cify)
_	ding I	ion	1  Natural 5 Pending (Month, Day, Year) Injury Work?	3d. Describe how	injury occurred	
VISION	Attending or death. ector: After by the fune	fical	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28	Bf. Location (Stre	et and Number or Au	ıral Route Number,
2	al or / s after I Dire	Certification: To	4 ☐ Homicide determined building, etc. (Specify)	City or Town,	State)	
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Af completely filled in by the fur	Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated			
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier 29c, License number	290	d. Date signed (Monti	h, Day, Year)
	F > F 0		Vamas horas AD DO6419	9	5-1-	09
	710		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			/
Ì	NV		James P. Jarboe, M.D. 24035 Three Notch Road, Hollywoo	od, MD	20636	
	Sta		31. Date filed (Month, Day, Year) V32. Registrar's Signature			
	Registr	ar	MAY 0 5 2009 Breez J. park			

09-03390 Charles H. Niles, Jr.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 14670

u1100   11   111100		1- For State Registrar	Certificate of	Death		Reg.	No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)	lles			2. Date of Death Month D	ay Year	3. Time of Death
edical Exami		4a. Facility Name (if not institution, give street and number)		lb. City, Town, or I	ocation of Death	April 27, 200	4c. County of Deat	h
		Civista Medical Center		LaPlata			Charles	(0)
Funeral Director			yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	<del></del>	8. Date of Birth(	MM/DD/YYYY) 9. Bii 941 Forei Co	ountry) MD
ny		Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Location	on				10d. Inside City Limits
Maryland 28a-f show any <u>d at once.</u>	_	D.C.	Washin	gton				1 X Yes 2 No
Maryla 28a-f d at or	Director	10e. Street and Number		10f. Zip Code		109	. Citizen of What Cou	untry?
ith the 23a or notifie		3913 1st Street SW  11 Marital Status 12. Was Decedent Ever	rin IIS 13 Wa	20032 s Decedent of His		pecify Yes or No-	USA 14. Race - Ame	rican Indian, Black,
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Montale filed within 72 hours after death with the Maryland for the filed prismarked other than "natural", or thems 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 X	If Yo	es, specify Cuban	, Mexican, Puerto	Rican, etc.)	White, etc.	
after cral", o	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1	Yes 2 X No		work done	Specify: B1	
2 hours "natu		15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  College (1-4 or 5+)	during m	ost of working life.	DO NOT use reti			
036 ithin 7 ne. r than 1edical	Completed	10	L.	aborer			Constru	ction
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a d	17. Father's Name (First, Middle, Last) Herbert Nil	les, Sr.		18.Mother's Name Sarah	e (First, Middle, Ma	Rogers	
212 ould be Menta marke	ro B	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing				er, City or Town, Sta	
Baltimore, MD remit. Pages 1 and 2 sho Department of Health and Important: If item 27 is njury or other traumati		Claudette Niles/Daughter	r 8561 20b. Place of Dispos				, MD 206	
Ore, ges 1 ar of Hea : If ite		1 X Burial 2 Cremation 3 Removal from State	crematory or ot	her place)				ke Bch.,MD
Baltimore permit. Pages 1 Department of 1 Important: If injury or other	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenseen					neral Ho Prince F	
Ba Pern Dep Imp		Glades a Sewell						red., MD
Physician /Medical		23a. Part I. Enter the disease, or complications that cau ed the failure. List only one cause on each line.						Between Onset and Death
xaminer	(i) (i)	Immediate Cause (Final disease or condition resulting in death)  a. Hypertens:  Due to (or as a consequence)		sclerot	ic cardi	ovasculai	disease	
	_	Sequentially list conditions, b	ence of):					
	Examiner	cause. Enter Underlying Cause						
xecuted η and - transit		events resulting in death) Last  Due to (or as a consequence)  d.						
0, e be exect ysician an	Medical	X UNPENDED AMENDED 23a, 2	7,perMĒ, g	3891 5/7/	/09 TT			
760, ficate be ex g physician s the burial	-	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of		etal death 3	Ectopic pregr	nancy	23d. Date of deliv Month	ery Day Year
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed hours after death.  Funeral Direction for this certificate has been signed by the attending physician and Funeral Direction, page 2 should be deached for use as the burial - trans	sician	past 12 months?	=	other (Specify)				
O. Bc t the dea by the a	Phys	Part II. Other significant conditions contributing to death but	ut not resulting in the	underlying cause	given in Part I.	23e. Did tol		to the cause of death?
, P.O ires that i signed b	d by					1 Yes		robably 4 V Unknown
of Vital Records, ig Physician: The law requir offer this certificate has been smeral director, page 2 should	Completed					24a. Was a autops perfor	sy prior t	autopsy findings available to completion of cause of ?
tal Rec tian: The la certificate h	E   S			26 Place	e of Death (Chec	1 Yes 2	2 No 1 🗸	Yes 2 No
Vital ysician: his certi director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 🗸 ER/Outpatien		Othor	- 11-1 - 17	Residence 6 Ot	her:
of V ing Phy After th	⊢	27 Manner of Death 28a, Date of Injury	28b. Time of		ury at Work?	28d. Describe h	low injury occurred	
Division tal or Attendin rs after death. al Director: /	catio	1 X Natural 5 Pending Investigation	y - At home, farm, stre		Yes 2 No	28f. Location (S	Street and Number or	Rural Route Number, City
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			nowledge, death occu	urred at the time, o	date and place, a	nd due to the caus	e(s) and manner as s and place, and due to	stated. the cause(s)
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.  29b. Signature and title of certifier	lation and/or investig		se number		29d. Date signed (	
		anote		0.0	.M.E.		April 28, 2009	
		30. Name and address of person who completed cause of deal		Ohne of Palit	050 MD 040	01		
		Ana Rubio MD. Assistant Medical Examin  31. Date filed (Month, Day, Year)  32. Registrar's		Street, Baltim	iore, MD 212			
Pagi	State	88 8 V - 4 0000 A	1 16	MIKE				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Wilma Florence Nickleson April 30 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golden Living Center Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov. 8, 1914 Birthplace (State or Foreign Country)
 WV Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🔽 F 94 Yrs 236-80-5512 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director MD Washington Hancock 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4 Fleming Drive Apt.C 21750 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or Items 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify. Specify: White δ 3 XWidowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Miller Lillian Combs or other traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy L. Wills/Daughter Fleming Drive Apt.C Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important; If its any Injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 05/04/2009 4 □ Donation 5 □ Other (Specify) Smithsburg, MD 21. Signature of Puneral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Amary Obs/rutine 14 con **Physician** disease or condition resulting in death) hrouge /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed bunial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 3 □Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 ☐ Unknowr been signed the should be detected 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy certificate 2 **X** No 1∐ Yes fo the Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 ☐ Pending investigation Injury (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed

Backs

368 mile

. Registrar's Signature

Street Hagestonn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 1<sup>Day</sup> APRIL 2009 0700 A M BARBARA J. POTOCEK 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death TALBOT EASTON HEARTFIELDS 8. Date of Birth 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Year 927 1 M 2 XX Months Days Hours Min. NY 81 132-18-2580 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County **XX**Yes 2 ☐ No SILVER SPRING MONTGOMERY 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 15101 GLADE DR. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo 14. Race - American Indian, 11. Marital Status 1 Never Married Married 1 ☐ Yes ZNo Specify: WHITE If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SCHOOL NURSE REGISTERED NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWINA ROGERS ROBERT EDWIN FITZGERALD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE P. GORDON DAUGHTER 8509 WILLIS DR. EASTON, MD 21601 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4-15-2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERCEROR 200 S. HARRISON ST. EASTON, MD 21601 JOHN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon 3485 disease or condition resulting in death) Concu Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🔽 2 No

Physician /Medical Examiner

Department of Health a Important: If item 27 Is any Injury or other traconce.

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

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"natural"

and Mental Hygiene.

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1

Hearthely 5

burial-trans

physician use as the attending ō the detached signed by t page 2 certificate Certification: To

After this funeral death. eral Director: Filled in by the fi ospital or A

requires that the death certificate be executed

P.O. Box 68760,

Records,

of Vital

Division

Attending Physician:

Hospital

Completed by Be

To the Hospital within 24 hours a To the Funeral C

8-RY-State

Examiner Physician/Medical IF FEMALE: 25. Was case referred to medical examiner? 1☐Yes 2☑No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

1 Certifying Pity lic an: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number R124198

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 4 551 51 50

28d. Describe how injury occurred

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

Com men Da #106, EASTIN, MD 21601 CKNP -8579 31. Date filed (Month

gistrar's Signature

Registrar

			For State		State	of Maryla	and / Depa					lental H	ygien	e	0.0		c -1 1
			Registrar  1. Decedent's Name (First.	Middle	201)		Ce	rtificat	e of L	Jeatn		2. Date of D	Reg. N	0.2	09	2 Time	6 / C
	Physici	an	,	,								Month	D	ay	Year		of Death M
	/Medio Examin		James Irv  4a. Facility Name (If not ins		Pratt ve street and n	umber)		4b. City,	Town, or	Location	of Death	April	24,	2009 c. County	of Death	1:33	p.m.
	Examili	iei	15671 Pratt					Ridg							iary'	S	
Т	Funeral		5. Social Security Number	6.	Sex 1.2XM 2.□F	7. Age (In y	rs. last birthday)	If Under Months	1 Year	If Under Hours	24 Hrs. Min.	8. Date of B (Month, I 05/24/				place (Stat	e or Foreign
	Director		217-32-0724		1LAM 2LF		77 Yrs.	Working	Days	Tiours	IVIII.	05/24/	1931	Ĺ	Mary		
	and		Usual Residence of Deced	County		10c.	City, Town or Lo	cation							1	Od. Inside	City Limits
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	r 28a	Director	10e. Street and Number	mary	/ 5	Ric	ige	10f. Zip	Code				10g. C	itizen of \	What Cou	ntry?	
	h with		15671 Pratt	Road				206	80				Uni	ited	Stat	es	
	ems	Funeral	11. Marital Status		12. Was Dec	cedent Ever in	U.S. 13.	Was Deced	dent of Hi	ispanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	lo-		ce - Americk, White,	can Indian,	
20	or it	by Fu	1 Never Married 2		1 (X)Yes If Yes, G	2 □ No Bive		1 □ Yes 2		Specify:				Specif		010.	
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ÿ	in 72 n "na	Completed	(Specify only		ade completed		1 (Give	kind of wor DO NOT us	rk dane a	turina mos	t of work	ing	100.1	KING OF D	usiiiess/iii	Quali y	
7	d within giene.	mo	Elementary/Secondary (	0-12)	College	(1-4or 5+)	Firef	ighte	r				U.S	. Go	vern	nent	
and	e filed al Hy l othe vent,	Be C	17. Father's Name (First, M	liddle, Las	t)					18. Mothe	er's Name	e (First, Middl	e, Maide	n Surnan	ne)		
Na Na	2 should be f and Mental I is marked of aumatic eve	일	George Will:	iam P	ratt					Hatt	ie E	lizabe	th N	lauma	n		
Маг	2 sho n and is m raum		19a. Informant's Name/Re	٠.			19b. Maili	ng Address	(Street a	and Numb	er or Run	al Route Num	ber, City	or Town,	State, Zij	Code)	
a,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my Injury or other traumatic event, fra I safe is a constant of the results of an once.		Audrey C. P: 20a. Method of Disposition		Wife	201						ge, MD	206		City or To	own, State	
2	ages nt of t: If ite		1 🗆 Burial 2 🗖 Crem	ation 3		State	<ol> <li>Place of Dispo cemetery, crea</li> </ol>			- 1							
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	/Medical		resulting in death)		a. Due to	o (or as a cons	juence of):	1	11	euci	T	di				1	( <u>)</u>
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_	isit is	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to	(or a a cons	equerice of):	- V24	· \							11	0
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5	th cer tendir r use	N/UE	IF FEMALE: 23b. Was decedent pregna			utcome of ore		⊒Èctópic p	//	u.					te of deli-		
	e dea the at red fo	Physician/Me	in the past 12 months	1?		gnant at time of		Other (sp		, 				Mo	onth	Day	Year
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5	ysicia is ceri	To Be	examiner? 1 ☐ Yes 2 ☑ No	icaicai	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3□DC	Othe	or:		me 5 Re		6 🗆 Ott	ner (Sneci	6/)	
5	ig Ph ter thi	ü	27. Manner of Death	D	28a. Date	e of Injury onth, Day, Year,	28b. Time o		8c. Injury Work	y at		28d. Describe		_	<del></del>	'9/	
2	endir sath. or: Af he fur	atic	2 Accident	Pending investigatio	n i	min, Day, rour,	,,,	М		Yes 2	No						
<u> </u>	or Att fter de irecte in by t	ertification:		Could not be determined	28e. Plac build	e of Injury - At ding, etc. (Spe	t home, farm, str ecity)	eet, factory	, office			28f. Location City or To	(Street a	and Numb te)	ber or Run	al Route N	umber,
2	oital c	O	200 Contifier														
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier 1 2 Ce (Check only 2 Me	edical Exa	miner: On the	ne best of my h basis of exam pner stated.	knowledge, deat ination and/or in	n occurred vestigation	at the tin , in my o	ne, date ai pinion, dea	nd place, ath occur	and due to the red at the time	e, date a	(s) and m nd place,	anner as and due t	stated. o the caus	e(s)
	No the	Me	29b. Signature and title of	certifier				290	. License	e number	(		29d. D	ate signe	d (Month,	Day, Year	)
			•	10	MAIL	lasto	EM 3		D	06	419	7		4 =	17 -	-09	}
•	10	ŀ	30. Name and address of p	erson who	completed cau	use of death (I	tem 28a) (Type,	Print)			· 1				7/		
	10		James P. Jan				Three No	otch l	Road	, Hol	.lywo	od, MD	20	636			
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	Registra	ar	APR 2	S 500	y died	Sold of the second	e. por	Med									

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			For State	State of Ma	arylanu / i			lealth and N		000	0 11 671		
		-	1 - State Registrar Certificate of Death Reg. No. 2 1 1. Decedent's Name (First, Middle, Last)								3. Time of Death		
	Physicia		Grace Walk				Day Year <b>2009</b>						
al.	/Medic Examin		4a. Facility Name (If not institution, gire	ve street and number)	4b.	City, Town, or	r Location of Death	4c. County of Death					
			Althea Woodland			5	ilver	Spring		Montgon	nery		
	Funeral				je (In yrs. last bii <b>95</b>	rthday) If L	nder 1 Year oths Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)		
	Director		Usual Residence of Decedent		93	Trs.			Aug 13,	1913 Sou	th Carolina		
	yland yland		10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits		
	e Mar ia-fsl	ctor	Maryland   Montgom	ery	Silve	r Spri	ng				1 XYes 2 □ No		
	or 28	Director	10e. Street and Number		,	10	f. Zip Code		10	g. Citizen of What C	ountry?		
	s 23a	iral	8201 - 16th Stre	~ -			20910			nited Sta			
	item item	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent   Armed Forces?		13. Was L	specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	te, etc.		
980	urs af	by	3 □ Widowed 4 □ Divorced	1 □Yes 2√1 If Yes, Give Year or Dates:		1 □ Y	es 2 XNo	Specify:		Specify:	African American		
2-0	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Modical Exaction of out by modified at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a	Decedent's		ation during most of work		6b. Kind of Business			
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and	d be f ental I red of c eve	) Be	Charlie Walk						,	,			
Maryland 21215-0036	should nd Me mark	욘	19a. Informant's Name/Relationship		198	o. Mailing Ado	dress (Street		ussie Gai ral Route Number.	City or Town, State,	Zip Code)		
ž	alth a 27 is sr trai		Issie L. Jenkin	s - Friend	12	826 Fc	rest C	reek Cou	rt Sykesv	ille, MD	21784		
altimore,	es ta of He fitem rothe		20a. Method of Disposition	75 44 60	20b. Place o	of Disposition ery, crematory	(Name of	;		Oc. Location - City o			
Ĕ	Page ment ant; I		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci					lens Apri	1 24, 200	9 Dreyto	on, SC		
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Exaction of the modified at once.		21. Signature of Fundal Service Lion 22. Name and Address of Facility Stewart Funeral Home, Inc.										
	ŭ D ≟ a ol		MOING !	Maller	SAL					ngton, DC			
	Physician /Medical		23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line.  Approximate Interval Between Onset and Death										
			disease or condition resulting in death)  a. 4rterioscipantic Cardiouasculan Disease yearing										
	Examiner		·	Due to (or as	a consequence	of):					1		
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,00	ite be executed ysician and e burial-transit		resulting in death) Last	Due to (or as									
	icate t physic the b	dical		<b>d</b>									
9 X	death certifical e attending phy d for use as th	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of pregnancy					COd Date of d	liver.		
Вох	death atter 1 for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death		pic pregnanc	у		23d. Date of do Month	Day Year		
О	t the c by the achec	hysi	9 Unknown	9 Unknown			(-77/						
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ğ	equire sen si ould t	bed	Congestivo 1	teart f					1 □ Yes	]Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown			
Vital Records,	law r nas be 2 sh	Completed	Atrial Fibi	Hatsor	1				24a. Was an autopsy	psy prior to completion of cause of			
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<b>o</b>	iding Physician: th. : After this certific funeral director, p	입	1 Yes 2 No  27. Manner of Death	28a. Date of Inju	ent 2 ER/Ou	utpatient 3[ Time of		4 La Nursing Ho	ome 5 Resider 28d. Describe hov	nce 6 Other (Sp	ecify)		
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בֿ	tal or rs afte al Dir	Cert			City or Town, State)								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, is	edical	(Check only 2 Medical Exal	hysician: To the best of miner: On the basis of	f examination ar	e, death occu	rred at the tir ation, in my o	me, date and place	, and due to the ca rred at the time, da	use(s) and manner te and place, and du	as stated. le to the cause(s)		
	the I	Med	29b. Signature and title of certifier	and manner sta		400	29c. Licens	e number	20	d. Date signed (Mor	oth Day Year)		
	5	=	P. Oh	Wester	e hul	7	ZOO. ZIOCHIO	7/552		DAY 3-	2 (100		
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	A.		PAUL A. DEVORE MD 4203 QUEENERUNG Rd HYETKVILLE MIS 20781										
	Stat		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature								
	Registra	ir	APR 2 3 2009	Server )	O. par	Ker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🕘 🗋 🗎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 0236 gm Dorothy Byrne Patterson 20,2009 ADMI /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dorchester General Hospital -ambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2X F New Jersey 214-52-0718 Aug. Director 87 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Modical Examiner must be retified at MD Dorchester Cambridge 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1724 Garden of Eden Lane 21613 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No white ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Robert Byrne Josephine Twachman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai once. Wilbert T. Patterson husband 1724 Garden of Eden Lane, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Spedden Seward Cemetery 4/22/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Thomas Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 41 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): It any leading to himedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b 24a. Was en 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate Division of Vital 2 No 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ospital or Attending hours after death. 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number

DHMH 17 Rev 1/2001

TERSON, DOR

Registrar

4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 20 2009 **Physician** 1:25 P M Poole Kathleen Torney /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 20 1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F Washington DC 577-38-8406 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at Maryland Calvert Lusby 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 765 Skyview Drive 20657 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. And I it item 27 is marked other than "natural", or Ite ury or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) health care office manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Torney Violet Dixon Melvin ပ 19a. Informant's Name/Relationship (Type. Print) Douglas G. Poble-son 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) P.O. Box 520 Huntingtown, Maryland 20639 permit. Pages 1 and 2 g Department of Health an Important: If item 27 is any Injury or other trau Metroposition (Name of April 1930 2009 20c. Location - City or Town, State Metroposition of the contract of th 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRausch Funeral Home, 21. Signature of Funeral Service Licenses 4405 Broomes Is. Rd. Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner ing physician and 9 as the burial-trans Due to (or as a consequence of) Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea: 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an this certificate has rat director, page 2 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: funeral director, After s after dec.
seral Director; A.
v filled in by the

with the Maryland

death \

Baltimore, Maryland 21215-0036

within 24 hours a

To the Funeral C

completely filled

To the !

State Registrar

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORIAL

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and fittle of certifier

32. Registrare Signature 2009

			State of Maryland / Department of Health and Mental Hygiene									00	1 1	c = 7 7				
_			State Registrar			Certificate of Death								Reg. No	20	09	14	511
н	Physic	an	1. Decedent's Nan	ne (First, Midd	le, Last)							2.	Date of D Month	Da	-	Year	3. Time	of Death
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-			Charlot 5. Social Security					1 t-: t	10.00		tte Ha	11	Data of D	S		lary'		e or Foreign
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	pu ,		Usual Residence		-		10-0"	T							710			
	laryla shov	ŏ	10a. State  Maryland	10b. County				ty, Town or L eensbo										City Limits es 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	the N	rect	10e. Street and Nu		Tue		GI	генаво		Zip Code				10a. C	itizen of	What Cou		7.
	h with 23a or	al Di	25817 Do		Road					21639				US.			,	
980	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Evention LAIST be in titled at	by Funeral Director	11. Marital Status  1 Never Mar 3 Widowed		ried 1	Decedent ed Forces? Yes 2 1 ies, Give r or Dates:		.S. 13.	Was Dec If Yes, sp 1 □ Yes	**	lispanic Originan, Mexican, I	n? (Specif Puerto Ric	y Yes or N an, etc.)	lo-		ck, White,	ican Indian etc. ite	
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ary		۳	19a. Informant's N	Name/Relations	ship (Type. Prin	t)		19b. Mail	ing Addre	ss (Street	and Number	or Rural F	Poute Num	ber, City	or Town	, State, Zi	p Code)	
	and 2 ealth a n 27 ls		Michelle	Wade/	Niece						Road,	Gree	ensbo	ro,	MD 2	1639		
Baltimore,	ges 1 t of Ho if iten or oth		20a. Method of Dis		3 ☐ Removal	from State		Place of Disp cemetery, cre				Date <b>Api</b>	il.	20c. L	ocation.	- City or T	own, State	
tim	t. Pag rtmen rtant: njury		4 Dipoplation	5 Other (5	Specify)		Br				Crem.	27,	200	9 C	har1	otte	Ha11	, MD
Bal	permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any injury or other trau once.		21. Signature of F	uneral Service	Licensee	A M	00817				ss of Facility  e Note							
	Physician /Medical Examiner	Examiner	Immediate Cause disease or condition resulting in death Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease or that initiated event resulting in death)	onditions, mmediate erlying tinjury	b c	CAR ue to (or as REA ue to (or as	D T a conseq 4 A L a conseq	uence of): - Fi uence of):		RHY	KTHM :	IIA					Interval I	
8760,	icate be executed physician and s the burial-transit	dical	d															
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	quires that n signed b ıld be deta										_	use contribute to the cause of death? □ No 3 □ Probably 4 ☑ Unknow						
Division of Vital Records,	ne law requir has been s ge 2 should	Completed by	ESSENTIAL HYPERTENSION								_	24a. Was an autopsy prior to corperformed?				opsy findin ompletion o	gs available of cause of	
ta	ician: The certificate h ector, page		25. Was case refe	rred to medica	1						00 Place 6	f Daath (	1 □ Yes		6	1 🗆 Yes	2,□160	
>	ysicis is cert direct	o Be	examiner?		Hospital	1 □ Inpatie	ent 2 🗆	LER/Outpatie	ent 3 🗆	DOA Oth	er: 4 Nurs	-0			6 □ Ot	her (Snec	ifu)	
on of	l or Attending Phatter death. Director: After th	tion: T	27, Manner of Death  Value of Injury  (Month, Day, Year)  28b. Time of Injury  (Month, Day, Year)  28c. Ir						DOA Other: 4 Nursing Home 5 Residence 6 Other (Special North Property of the P					,,,				
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	To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one)	1 Certifyi 2 Medical	ng Physician: I Examiner: Or and	To the best the basis of manner sta	f examina	owledge, dea ation and/or i	ath occurre investigati	ed at the ti	me, date and opinion, death	place, and occurred	d due to th at the time	ne cause( e, date ar	s) and n	nanner as , and due	stated. to the caus	e(s)
	To t	Ž	29b. Signature and	d title of certifie	er ,	MD			2	29c. Licens	e number 77 88	3					, Day, Year	
	18 112.		30. Name and add	ress of nerson	who complete	d cause of d	eath (Iter	n 23a) /Tvno	Print)									

State Registrar

31. Date filed (Month, Day, Year)

LEENA

RAO

KODALI 29449 Charlotte Hall Rd., Charlotte Hall, MD 20622 32 Registrar's Signature APR 28 2009

Physicia /Medic Examin	ε
Funeral Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expandent must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	Certificate of Death Reg. No.								
	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day Yea	3Time of Death			
ian cal	MINNIE	ROSS			APRIL	20 2009	10:10 A M			
ner	4a. Facility Name (If not institution, give street and number)	4	4b. City, Town, or LANHAM	Location of Death		4c. County of D	eath			
	MAGNOLIA NURSING HOME		GEORGE'S							
	5. Social Security Number 6. Sex 7. Age (In yrs. la	01 211 11104)/	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	th 9. Birthplace (State or Foreign Country)				
	202-30-0900	Yrs.			APRIL	16 1920 S	OUTH CAROLINA			
		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location								
ō		1 <b>X</b> Yes 2 □ No								
ect	MD PRINCE GEORGE S	Т	10g. Citizen of What Country?							
	5410 67th AVENUE		10f. Zip Code 20737	Ü	Country !					
era	11. Marital Status 12. Was Decedent Ever in U.S	13. Wa		spanic Origin? (Sp	USA 14. Bace - A	merican Indian.				
듄	Armed Forces?  1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No			spanic Origin? (Sp n, Mexican, Puerto	Black, W					
5	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 [	⊒Yes 2∏No	Specify:	Specify:	BLACK				
Completed by Funeral Director	15. Decedent's Education	16a. Decede	nt's Usual Occupa	ation Juring most of worki		16b. Kind of Business/Industry				
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Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Surname)				
ျ	WILLIAM H. EPPS			VIO	LA BA	ILEY	_			
	19a, Informant's Name/Relationship (Type, Print)	9				er, City or Town, Stat				
	SAMUEL ROSS SR./HUSBAND			NUE RIVER			)737			
	IXI Burial 2   Cremation 3   Removal from State		tion (Name of tory or other place		Date	20c. Location - City	or rown, State			
				TERY, 4/28		CHELTENHAN				
1	21. Signature of Seperal Service/Licensee		Name and Addres	•			NERAL HOME			
_		ER, MARYLAN								
	shock, or heart failure. List only one cause on each line.	Onset and Death								
	resulting in death)	ION PNEUMONIA								
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Exa	resulting in death) Last  Due to (or as a consequence)	ence of):								
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	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal	cy death 3.⊟F	Ectopic pregnancy	1	23d. Date of					
Completed by Physician	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of de		Other (specify)			Month	Day Year			
Phy	9 LI Unknown				00 0111					
þ	Part II. Other significant conditions contributing to death but not resul	ting in the und	erlying cause give	en in Part I.			e to the cause of death?			
ted					101	Yes 2 No 3 No	Probably 4 1 Unknown			
헏		osy   prior	e autopsy findings available to completion of cause of							
ខ្ល	performed? death? 1 □Yes 2 ☒No 1 □Yes 2 ☒No									
B	25. Was case referred to medical examiner?									
은	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	dence 6 Other (5								
ië E	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	now injury occurred								
2 Accident investigation M 1 Yes 2 No 1 Yes 2 No 2 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Insert Section 1)										
erti	4 Homicide determined building, etc. (Specify)		28f. Location (Street and Number or Hural Houte Number, City or Town, State)							
a C	r as stated.									
Medical Certification: To	due to the cause(s)									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,										
	I ME MA M	~)		D32261		APRIL 22,	2009			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	RICHARD J. FELDMAN 9500 ANNAPO		AD SUITE	E A-4 LANI	HAM, MA	RYLAND 20	706			
ate rar	31. Date filed (Month, Day, Year)  APR 2 3 2009  32. Registrar's Signatu	have								
CII.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 April 12:30 p<sup>M</sup> Gene Marie Robinson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 26 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** <sup>Year)</sup> 1929 Days Min. Months Hours 1 □ M 2 1 F Yrs 79 MD Director 214**-**24**-**7368 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mential Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County traumatic event, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director Baltimore MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21214 2913 Shirey Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: Specify: White ģ 3 ☐ Widowed 4 X Divorced Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American National Bank Loan Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Marie Arnold ( unknown ) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 21158 2645 Robert Arthur Road Westminster, MD Paul Robinson/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/20/2009 Hampstead, MD Carroll Cremation, Inc 4 ☐ Donation 5 ☐ Other (Specify) Prints Forestal Home and Chapel, P.A. 21. Signature of Funeral Service Licenses Westminster, MD 412 Washington Road 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 40 Physician a Heute Beacenhatun COPM disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ten Quiu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): signed by the attending physician and I be detached for use as the burial-tran P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ■No this certificate 2  $\square$  No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural **Division** 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 0

State

29a, Certifier

29b. Signature and title of certifier

Hetander P Date filed (Month, Day, Year)

APR 22

30. Name and address

Registrar DHMH 17 Rev 1/2001 manner stated

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician. To the best of my mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician 1:45 pm 2009 Anahid Margaret Staffier April 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Director 93 January 4, 1916 Massachusetts 028-05-2271 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, it. 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20905 14 Aylesbury Court Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. □Yes 2XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Specify. Specify. \$ 3 Widowed 4 N Divorced Caucasian Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Beautician Cosmotology 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once. ၉ Bedros Torokhanian Ida Sarmanian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan C. Hull - Niece 13727 Shannon Avenue, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Memorials 04/24/2009 Everett, Massachusetts 22. Name and Address of Facility Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA. MODE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 2 X No P.0. ned by the a detached f 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has s certificate ha irector, page 2 autopsy performed 1 ☐Yes 2 🗷 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🕱 No 1 🗷 Inpatient ၉ 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONILLUE

31. Date filed (Month, Day, Year)

D0065 024

18101 Prince Philip Dr; Olney, MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month

1. Decedent's Name (First, Middle, Last) **Physician** 2009 DIANA STRANAHAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner The Memorial 12/bot Hospita Esston If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 💥 F Months Yrs. Director 52 AUG 5, 1956 VA 214-68-5692 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Widdell Event has must be notified at 1 Yes XX No Director QUEEN ANNE'S **OUEENSTOWN** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 148 COOPER FARM LANE 21658 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XXO 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify \$ 3 ☐ Widowed 4 Divorced WHITE Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PHARMACY TECHNICIAN HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OLLIE J. THOMAS, SR. VIRGINIA TURNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or and DONALD STRANAHAN JR. SON 6003 GRAND PALM DR. APT 721 TAMPA, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) DENTON CEMETERY 4-25-2009 DENTON, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 S. HARRISON ST. EASTON, MD 21601 21. Signature of Funeral Service Licensee Ostrowsk. HOME, P.A. C.F.SP Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter third-righing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): physician a s the burial-Box 68760. Physician/Medical signed by the attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) P.0. 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 2 🗌 No 3☐ Probably 4☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has certificate 2 🗆 No 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ↑ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | №0 Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after co....
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) K Rainem MD D 66441 APRIL 2151- 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMESH 2195 Kolli STREET Easton, MD washington Registrar's Signature State Registrar

Digna

strangen,

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 0130 A M EDWARD J. SHEA aka EDWARD J. SHEA, JR. APRIL 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT EASTON 29863 NICHOLAS WAY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12-17-1936 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. XXM 2 F 72 Director 054-30-6423 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at XXYes 2 No Director MD TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21601 29863 NICHOLAS WAY Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XX s 2 No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes XXNo \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene.

27 is marked other than "r
r traumatic event, in the Med Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be JULIA CARROLL EDWARD J. SHEA SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 29863 NICHOLAS WAY EASTON, MD 21601 BEVERLY M. SHEA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 4-21-2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON ST. EASTON, MD 21601 21. Signature of Funeral Service Licensee JOHN R MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting indepth least Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 1 □Yes 25 1 ☐Yes 2 ☐No or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After s after dea... al Director: Aft 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 20a) (Type, Print) 12+VA 8991 31. Date filed (Month. State

DHMH 17 Rev 1/2001

Registrar

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permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tronge.		20a. Method of Dis			20b.	Place of Dispo cemetery, crea				Date		20c. Lo	cation - City o	r Town, State	9
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permit. Pag Department Important: I any Injury o		21. Signature of F	uneral Service L	icensee		F	ELLO!	NS, Address	ELFENBE	IN	& NEW	NAM 1	FUNERAI	HOME	, P.A.
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leath certificate b	Physician/Medica	IF FEMALE:		23c. If yes, outco	me of prean	ancv			***				23d. Date of d	olivory	
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t the c by the achec	hysi	1 ☐ Yes 2 9 ☐ Unknow	A NO	9 🗆 Unknov	vn			, ,,							
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equire sen si ould b			Dement	(0)					****	-	1 🗆	Yes 2[	□ No 3□	Probably 4	Unknown
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ath. r: Afte	atio	Natural 2 Accident	5 Pending investiga		Day, Year)	Injury	М		es 2 □ No						
r Atte er deg recto	ertification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	28e. Place of	f Injury - At h	iome, farm, sti ify)	eet, factor	y, office		281	f. Location (		d Number or	Rural Route	Number,
ital or ral Di	C														
To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	2 ☐ Medical E	p Physician: To the b examiner: On the bas and manne	sis of examin	owledge, deat ation and/or ir	th occurred evestigation	d at the tim n, in my op	e, date and plainion, death or	ace, an ccurred	d due to the at the time	e cause(s , date and	) and manner d place, and d	as stated. ue to the cau	se(s)
To th within To th comp	Me	29b. Signature and	d title of certifier	Who X	MA		29	c. License	number	7-7		29d. Dat	te signed (Mo.	nth, Day, Yea	ar)
-10				14/1/11	m/			Y	1593	7			4119	1.,09	
3		30. Name and add	Iress of person w	vho completed cause	of death (Ite	m 23a) (Type,	Print)	ĆHMI	ANS L	AN	Z	LAS	TON 1	10 3	21601
	ate trar	31. Date filed (Mo	R 16 20	09 Sina	gistrar's Sign	ature aux	1	-					, , ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $20^{\text{Day}}$ April **Physician** 200°9° 1:10 A David R. Shriver /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/06/1935 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 185-28-3536 73 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or rother traumatic event, the Medical Examiner must be notifiled at any Injury or other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 No Maryland Wicomico Salisbury Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21804 USA 1002 Arthur Ct., Apt. 562 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Navy Year or Dates: Navy 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: ģ white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sollege (1-4or 5+) Elementary/Secondary (0-12) sales representative drafting materials 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Sandt David R. Shriver ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4134 Elk Creek Dr., Salisbury, MD 21804 Doug Shriver/son Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I Springhill Memory 1X Burial 2 ☐ Cremation 3 Removal from State 4/24/09 Hebron, MD 4 Donation 5 Dother (Specify) Gardens 21. Signature of Pheral Service Licenses Nam and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHEUNIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to kinh order cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for ex a nonsequence of Examine certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4□Pregnant at time of death 5 Other (specify) 1□Yes 2□No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Tes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 212No 2 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 1/6 ၉ 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA this e Hospital or Attending Ph 124 hours after death. e Funeral Director: After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🗓 Matural 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Chuy Ng

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maesha Thimmarayappa, MD 614 Easternshore Dr., Salis., MD 21804

31. Date filed (*Month*, *Day*, Year)

APR 2 2 2

32. Registrar's Signature

B. Sark

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Shinton :59 AM Harry Stephen Jr. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner oastal the Wicomico 14050; CR at >a/i If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Days 1 X M 2 ☐ F Months Hours 186-24-0863 84 06/05/1924 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 USA 611 Tressler Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: Navy 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: þ white 3 K Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4or 5+) education teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Stephen Shinton Sr. Emily Tompkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26800 Pemberton Dr., Salisbury, MD 21801 Susan Marie Bounds/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 4/21/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stag disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as consequence of): Physician/Medical <u></u> Be Completed

**Physician** /Medical **Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exercitive is usine to utilised at

Baltimore, Maryland 21215-0036

HARRY

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans attending physician for use as the buria detached signed I page 2 should has certificate director

Division of Vital Records, P.O. Box 68760

	d	
IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobar	cco use contribute to the cause of death?
	1 □ Yes	2 No 3 Probably 4 Unknown
	24a. Was an autopsy performe 1 □ Yes 24	
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	ce 6 Other (Specify) OS) (C
27. Manner of Death  1 → Natural 5  Pending 2  Accident investiga		injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		et and Number or Rural Route Number, State)
29a, Certifier Certifying	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau	ise(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

29d, Date signed (Month, Day, Year)

gu/g

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

Certification: To

Medical

29b. Signat

Name and

31. Date filed (Month, Day, Year)

22

MD

address of person who completed cause of death (Item 23a) (Type, Print)

elle

Registrar's Signature

		•	1 - State Amend Items 25,27,28 aryland	r Depa Cer	g <b>894n,bsf/ds469at</b> tificate of Death	<b>րե</b> Mental Hyg ւ	giene Reg. No. 2009	14686
		X.	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	ath Day Year	3. Time of Death
*	Physicia /Medic		Donald I. Shea	rer		Apri1	17 2009	1335 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of I	Death	4c. County of Deat	h
enti."			Union Hospital	of hinth dough	E1kton  If Under 1 Year   If Under 24	Hrs. 8. Date of Birt	Cecil	hplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	Yrs.		Min. May 23	y, Year) Co	ennsylvania
	Director		171-10-4938 95 Usual Residence of Decedent			May 25	, 1915   1	elilisyivalita
	yland now		10a. State 10b. County 10c. City,	Town or Lo	cation			10d. Inside City Limits
	n the Maryland יי 28a-f show	ctor	Maryland Cecil E	lkton				1 □Yes 2 ሺ No
	ith th	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
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Š	in 72 hours after death with "natural", or items 23a or ledical Examiner must be	ted		16a. Deced	dent's Usual Occupation kind of work done during most o	d wanting	16b. Kind of Business	
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7	ed wil	Completed	12	Su	pervisor		Manufact	uring
ב	be fill htal H ed oth even	Be	17. Father's Name (First, Middle, Last)			Name (First, Middle,	Maiden Surname)	
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ē,	is 1 and 2 of Health item 27 i		20h Blo	on of Diona	oition (Mama of	oril 23,	20c. Location - City or	
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Baltimore,	permit. Pages Department of Important: If it any injury or conce.		21. Signature of Funeral Service Licensee		Name and Address of Facility ICKS Home for F			
'n	Pe B B B B B B B B B B B B B B B B B B B		Donerd S. truks	10	03 W. Stockton	Street, El	kton, MD	21921
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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9	ertifica ling pl e as t	ധ	IF FEMALE:			<i>y</i>		
BOX	death certifi e attending d for use as	sician/M	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal c	death 3	Ectopic pregnancy		23d. Date of de Month	livery Day Year
_•	he de / the a	ysic	1 ☐ Yes 2 ■ No 4 ☐ Pregnant at time of de: 9 ☐ Unknown	ain 5L	Other (specify)			
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Division of	ttend death stor: / the f	icat	ZEMOCIDENT	Jnknov ne farm str				tural_Route Number.
2	for A after Direction by	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At hom building, etc. (Specify)  Assisted Liv	ving l	Facility	City or To	Street and Number or F wn, State) Colon: Elkton, MD	ial Manor
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	thin 2 thin 2 the I	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th. Day, Year)
	<b>5</b>	-	29b. Signature and title of certifier		D004771	\	April a	
			30. Name and address of person who completed cause of death (Item)	23a) (Tyne	Print)	•		
			DAVID GAK-EL 304-306 Nor	+L 5	treet Sult #3	ELKTOW	MAKTLAND	21921
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ire				
	Registr	ar	6 8 7 0 5 8000 A A A	and .	7			

			_	State of Maryla					-	iene	•
			1 - For State Registrar				of Dea			2009	14687
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	/Media	al	) immy Lei	e sren	APIR				April	27 200	09 1715 M
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	Funeral		Social Security Number 6. Sex	7. Age (In yrs		If Under 1	1 Year   If Un	nder 24 Hrs.	8. Date of Birth	9. E	Birthplace (State or Foreign
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	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation		-			10d. Inside City Limits
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	or 28	Funeral Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·		10f. Zip (				og. Citizen of What	Country?
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ylaı	should b nd Ment marked umatic e	To	E1me	er Stemple			Mi	na Vi	rginia	Wotring	3
Maryland 21215-0036	d 2 sh h and 7 ie m traum		19a. Informant's Name/Relationship (Ty) Elsie Stemple	pe, Print)					WV 26	City or Town, State	, Zip Code)
	t and Health tem 27		20a. Method of Disposition	20b.	Place of Dispo cemetery, cre			,	-	20c. Location - City	or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show any fujury or other traumatic event, the Medical Examinat must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	dinoval nom State  .	cemetery, cred rora_(	_		5/1/0	09 A	urora,	WV
alti	permit. Page Department Importent: if any injury or once.		21. Signature of Funeral Service License		1.7			-			
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	hed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bys to (or as a conse	quence of):						
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s, P	Attending Physicien: The law requires that the death certifica crash.  ected alth.  ected the this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying car	usa given in Pa	art I.	23e. Did tob	acco use contribute	to the cause of death?
ord	een si	ted	Wilms to	chror					1 ☐ Ye	s 2□No 3□	Probably 4 Junknown
Records,	e law has b	Completed	It y perfeasts	2					24a. Was ar autopsy perform	y prior t	autopsy findings available o completion of cause of
ē	in: Th ificete or, pag	e Co	25. Was case referred to medical						1 ☐ Yes 2	1 Y	es 214No
<u> </u>	ysicie is cert direct	To B	examiner?	ospital: 1  Inpatient 2 1	R/Outpatier	nt 3 DOA	Othor		n <i>Check onl</i> y one me 5 ☐ Reside	nce 6 ☐Other (S	pecify)
0	ng Ph Ifter th		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28	lc. Injury al Work?			w injury occurred	
Division of Vital	ttendi death. ttor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	One Phone of Injury At h		М	1 Yes 2		201 1 - 1 - 101		
<u>&gt;</u>	after after Direct d in by	Certification;	4 Homicide determined	28e. Place of Injury - At It building, etc. (Special	ify)	eet, tactory,	οπισε		City or Town		Rural Route Number,
	To the Hospital or Attending Physicien: The law within 24 burus after death.  To the Funerel Director: Atten this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, deat	h occurred a	t the time, date	e and place, a	and due to the ca	use(s) and manner	as stated.
	the H hin 24 the F uplete	Medical	0,110,	and manner stated.	ation and/or in						
	5 1 kg		29b. Signature and the of certifier			2 290.	License numb	THE C	29	od. Date signed (Mg	mm, Day, Year)
7			30. Name and address if person who con	mpleted cars of death (ite	m 23a) (Tvpa.	Print)	1216	0		(120/6	1
			DI SALLORDUNDUA RH	-1 BOX 541 TO	120 00	ta, Wi	12676	04			
- 1	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	B B	on No. I				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	A. So	arthor	<u> </u>	· · · · · · · · · · · · · · · · · · ·		

			For State	State of	f Marylar		artment of F rtificate of		nd Mental I		000	0 11 000
		-	Registrar  1. Decedent's Name (First, Middle, La	ast)			incate of	Dealii	2. Date of	Reg. No.	200	3. Time of Death
	Physici		Ste	ephen Skan	der Tabr	i.			Month April	Day		10.30 2
and the last	/Medio Examir		4a. Facility Name (If not institution, gi				4b. City, Town, o	r Location of			County of De	ath
			Holy Cross	Hospital				lver Spr				ntgomery
	Funeral			Sex 1⊠M 2□F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Date of (Month	Birth , Day, Year)	9. B	irthplace (State or Foreign Country)
	Director		215-82-0565 Usual Residence of Decedent	1 E3 W. 2 L. 1	87	Yrs.			Decemb	er 26,	1921	Palestine
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Mary I-f sh	ţċ	Maryland Montgo	merv			Ro	ckville				1 □Yes 2 No
	n the	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What (	Country?
	th wit		4905 Melind	Court				20853			U.	S.A.
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Exporage must be puttled at	Funeral	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	.S. 13.	Was Decedent of H	lispanic Origi an, Mexican,	in? (Specify Yes or Puerto Rican, etc.	No-	14. Race - An Black, Wh	nerican Indian, ite. etc.
36	s afte	by Fu	1 Never Married 2 Married	1 ∐Yes If Yes, Giv	2 <b>▼</b> No ⁄e		1 ∐Yes 2. No	Specify:			Specify:	
21215-0036	hours tural	d be	3 Widowed 4 Divorced	Year or Da	ates:	16a Daga	dent's Usual Occup	otion		16h K	ind of Busines	White
15	- 4 39	plet	15. Decedent's E (Specify only highest gr	ade completed)		(Give	kind of work done DO NOT use retire	durina most c	of working	TOD. K	ind of busines	5/ITIQUSTI y
212	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)  12	College (1	-4or 5+)		Owne				Restau	ırant
	be filed within 72 hours after death with the Marylan ital Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Experient mittle to retified at	Be C	17. Father's Name (First, Middle, Las	")				18. Mother's	s Name (First, Mid	ldle, Maiden	Surname)	
<u>Va</u>	should be filed withir and Mental Hygiene. s marked other than umatic event, ITEM	P	Elias :	Cabri					Thuria	Ableh		
Maryland	S an an		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number	or Rural Route No	ımber, City d	or Town, State	, Zip Code)
	1 and 2 Health em 27 ther tra		Elias S. Tabri - Son	1	les s		Dumfries	Road, Ma				T. 0111
Baltimore,			20a. Method of Disposition 1   Burial 2 □ Cremation 3		State	cemetery, crer	sition (Name of natory or other plac	1	Date		•	or Town, State
₽	nit. Pa artmen ortant; injury e.		4 Donation 5 Other (Special	•	Ga		eaven Cemeter  2. Name and Addre		04/23/2009	Silv	er Sprin	ng, Maryland
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	Dom	-eQ	7   H	lines-Rinal	di Funer	ral Home, I e Avenue, S	nc. ilver S	Spring, N	laryland 20904
			23a. Part 1. Enter the disease or con shock, or heart failure. List on	plications that co	aused the deat ach line.	h. Do not ent	er the mode of dyi	ng, such as c	ardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pne	umonia							Onset and Death
-1	/Medical Examiner		resulting in death)	Due to (	or as a conseq	uence of):						
		ia l	Sequentially list conditions,		onary Ar		ease					
B	uted d ansit	Examine	if any, leading to immediate cause. Enter Underwing Cause (Disease or injury that initiated events		ated Car		ıthv					
ó	exection and an analytical		resulting in death) Last		or as a conseq							
68760,	ficate be executed physician and s the burial-transit	edical		d. Pul	monary H	ypertens	ion					
•	ertific ling p	Med	IF FEMALE:							- 1		
Box	eath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?		oirth 2 🗀 Feta	aldeath 3 □	Ectopic pregnanc	y:		1	23d. Date of d Month	lelivery Day Year
0	the s	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ⊔ Pregr 9 □ Unkn	nant at time of o own	death 5∟	Other (specify) _			-		,
σ.	The law requires that the death certil ate has been signed by the attending page 2 should be detached for use a		Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. [	id tobacco u	use contribute	to the cause of death?
Vital Records,	uires n sign ld be	d by							1	□Yes 2	<b>⊠</b> No 3 □	Probably 4 Unknown
00	w requir s been s should	Completed							24a. V	Vas an	24b. Were	autopsy findings available
æ	The lav	mo				-			P	utopsy erformed?	prior to death	o completion of cause of ?
tai		Be C	25. Was case referred to medical				<del> </del>	26 Place o	f Death (Check or	s 2 🗷 No	1 1 14	es 2 No
<u>&gt;</u>	ys dirib	To B	examiner? 1 ☐ Yes 2 🍱 No	Hospital: 1酉।	npatient 2	ER/Outpatier	nt 3 DOA Oth	er.	sing Home 5 🗆 F		6 ∐Other <i>(Si</i>	pecify)
		<u> </u>	27, Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date	of Injury h, Day, Year)	28b. Time of Injury	28c. Inju			be how injur		
Θ̈́	Attending r death. ector: After by the fune	äţi	2 ☐ Accident investigation	n		, ,		Yes 2 □ No	0			
Division	lor Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	Zoe. Flace	of Injury - At he	ome, farm, str	eet, factory, office			n (Street ar Town, State		Rural Route Number,
	pital o		20a Cartifier 15 Cartifier 5	hygioleg: T- 41 -	host of muclim	aulodeo de l'	h acquired of the "	mo date - :	I place d	the co '	) and	an stated
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	29a. Certifier 1	miner: On the back and manr	asis of examina	ation and/or in	h occurred at the ti vestigation, in my	me, date and opinion, death	n piace, and due to h occurred at the ti	tne cause(s me, date and	d place, and d	as stated. ue to the cause(s)
_	Vithi Vithi Com	Ź	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	te signed (Mo.	nth, Day, Year)
	ا جا		10					D005610	8		April 1	9, 2009
			30. Name and address of person who	•		,						
	- 64-	to	Mary E. Wright, M 31. Date filed (Month, Day, Year)		Forest G egistrar's Signa		, Silver S	pring, N	daryland 20	910		
	Sta Registr		ADD 2.2.20		and a d	A Sac	Made					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29d per phys. G892 6/19/09 dk

Amend Item 29d per phys. G892 6/19/09 dk

Maryland Department of Health and Mental Hygiene [] [] 9 14689 Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 7:00 AM 04 Catherine 2009 TAYLOR 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Albot 1075 tew Social Security Number 18-16-8532 Ward H If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 02-03-1916 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Days 9 3

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28s-1 show any injury or other traumatic event. The Medical Examinat must be notified at once. Baltimore, Maryland 21215-0036

For State Registrar

1-

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Physician /Medical Examiner

ed by the attending physicien and detached for use as the burial-transit certificate has been signed by rector, page 2 should be detact within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director,

to the Hospital or Attending Physician: The law requires that the death certificate be executed

 $\#\mathcal{A}\mathcal{H}$  Division of Vital Records, P.O. Box 68760,

	Usual Hesidence of Decedent				10.11.11.00.11.11.		
	10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits		
ţō	MD Talbot	- (	extord		1 XYes 2 □ No		
9	10e. Street and Number	3	10f. Zip Code	10g. C	itizen of What Country?		
by Funeral Director	107 Stewar	t Ave.	21654		USA		
ner	11. Marital Status	Was Decedent Ever in U.S.     Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - American Indian, Black, White, etc.		
正	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:	,	Specify: Rical		
d b	3¥Widowed 4 □ Divorced	Year or Dates:		100	DIACK		
lete	15. Decedent's Educa (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 160.	Kind of Business/Industry		
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Irab Picker	A.	B. Harrison Co.		
Be	17. Father's Name (First, Middle, Last)	0	18. Mother's Na	me (First, Middle, Maide			
10	Henry	Cooper	He	nrietta	. Price		
	19a. Informant's Name/Relationship (Typ	1 16200	Mailing Address (Street and Number or Ri		and a series I		
	Samuel Tayl	01/0		exford, MI			
	20a. Method of Disposition  1	moval from State cemeters	Disposition (Name of y, crematory or other place)		Location · City or Town, State		
	4 ☐ Donation 5 ☐ Other (Specify)	Screa	mersville 041	10/09	xford, MD		
1	21. Sign ture of Funeral Sovice Licens	111).	22. Name and Address of Facility				
	105510	Hatm	426 Dover Stree		M D × 160		
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not cause on each line.	ot enter the mode of dying, such as cardia	c or respiratory arrest,	Interval Between Onset and Death		
	Immediate Cause (Final disease or condition	Atlasone	lerotic Heet d	esease			
	resulting in death)	Due to (or as a consequence of	of):				
٦	Sequentially list conditions, b	Due to (or as a consequence of	of)·				
ulue	Eequentially list sundificities, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence o					
xan	that initiated events c. resulting in death) Last	Due to (or as a consequence of	of):				
by Physician/Medical Examiner	d.						
edi							
IIV.	23b. was decedent pregnant	lc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy	9	23d. Date of delivery		
sicia	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of death	5 Other (specify)		Month Day Year		
hys	9 □Unknown						
by	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the cause of death?		
ted				1 🗆 Yes	2 No 3 Floodby 4 Albertain		
Completed	HTN			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
Con	Dyslig	alderia		performed? 1 □ Yes 2,0			
Be	25. Was case referred to medical examiner?			ath (Check only one)			
မ	1 □ Yes 2 No	ospital: 1 Inpatient 2 ER/Out			6 ☐Other (Specify)		
on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury 28b. T	njury Work?	28d. Describe how in	jury occurred		
cati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2 ☐ No	Cor I amble (Chart	and Alicenter on County County Alicenter		
E	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	City or Town, Sta	and Number or Rural Route Number, ate)		
S	202 Cartifier 10 Cartifuing Danie	isian: To the heet of my knowledge	death accurred at the time, date and ples	a and due to the cause	(c) and manner as stated		
Medical Certification;			, death occurred at the time, date and placed/or investigation, in my opinion, death occ				
Mec	29b. Signature and title of certifier	and the state of t	29c. License number	29d. [	Date signed (Month, Day, Year)		
1	DA1 1-H	UN	D/335	9 AT	oril 17, 2009		

State

Registrar

pare

in Street : Campidge, MO-21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 17

			State of Maryland / Dep  1 - State Registrar Ce	artment of Health and f <i>rtificate of Death</i>	vientai Hygier Reg. ۱	2000 1.200		
	Bloodel		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Oay Year 3. Time of Death		
	Physici /Medio		Jacqueline S. Turner		04 1	9 2009 11:05 A <sup>M</sup>		
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
			501 Main St. Apt. #425 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Laurel If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince George's		
	Funeral Director		579-54-5422 1	Months Days Hours Min.	(Month, Day, Yea 11/11/194			
	D		Usual Residence of Decedent					
	arylar show	7	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	the M 28a-f lotifie	Director	MD Prince George's Laure1  10e. Street and Number	10f. Zip Code	100.0	Citizen of What Country?		
	with yard	0	501 Main Street Apt. #425	20707	US			
	death ms 2: r mus	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerti		14. Race - American Indian,		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the McKeal Examiner must be notified at once.	by Fu	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give  3 ☑ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	o nicari, etc.)	Black, White, etc.  Specify: Black		
5-0036	2 hour	ted I	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b.	Kind of Business/Industry		
21215	thin 7; re. ran "n	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of wor DO NOT use retired)				
21	ed wi lygier her th			itive Secretary		S. Customs Service		
Maryland	should be filed within the Mental Hygiene.  marked other than " umatic event, Ingless	Be	17. Father's Name (First, Middle, Last)	Lillie I	ne (First, Middle, Maid C. C	en Surname)		
Ž	should of Me mark matic	은	Walter T. Scott, Sr.  19a. Informant's Name/Relationship (Type. Print)  19b. Mail	ing Address (Street and Number or Ru	-	y or Town, State, Zip Code)		
	nd 2 saith au 27 is 27 is r trau			Gannon Ct., Sever				
ore,	es 1 and 2 of Health of item 27 is rother tra	1 %	20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place)	Date 20c.	Location - City or Town, State		
Ē	Pages ment of I ant: If ite	8	4 □ Donation 5 □ Other (Specify) Ft. Linco	1n Cemetery 4/25		entwood, MD		
Baltimore,	permit. Departr Importa any Inju		A -0	2. Name and Address of Facility Ma				
	TO = 60 O	10.	23a. Part Enter the disease, or complications that caused the death. Do not en	4217 9th St NW Wa		C 20011 Approximate		
E	Dharistan		shock, or heart failure. List only one cause on each line.		or respiratory arrest,	Interval Between Onset and Death		
	Physician / /Medical		disease or condition resulting in death)  A. Metastatic Carc Due to (or as a consequence of):	inoma to Brain				
	Examiner		Endometrial Car	cinoma				
	p ti	iner	Sequentially list conditions, if any, leading to financiate cause. Enter Underlying Cause (Disease or injury that sittles are to consequence of the conditions).					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of);					
68760,	ificate be executed g physician and is the burial-transit		bue to (or as a consequence of).					
687		edical	d	1727				
Box	eath certific attending pl for use as t	M/ue	IF FEMALE: 23b. Was decedent pregnant is the part 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery		
O. II	The law requires that the death cert ate has been signed by the attending agge 2 should be detached for use a	Physician/M		Other (specify)		Month Day Year		
σ.	ires that the de signed by the a d be detached i		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?		
of Vital Records,	uires t signe Id be (	d by	Diabetes Mellitus		1 ☐ Yes	2 No 3 Probably 4 Number		
S	w requir s been s should	Completed	Hypertension		24a. Was an	24b. Were autopsy findings available		
æ	The law cate has page 2 s	omp			autopsy performed 1 □ Yes 2 🔀	prior to completion of cause of death? No 1 □ Yes 2 ☑ No		
ital		Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)	NO TENO EMI		
ž V	ilis dir		1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			6 ☐ Other (Specify)		
	fe fe	jon:	27. Manner of Death  1 X Natural 5 Pending (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	Work?	28d. Describe how in	njury occurred		
Division	Attending ir death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st		28f. Location (Street	and Number or Rural Route Number,		
Θ	al or A after I Dire d in b	Certification: To	4 Homicide determined building, etc. (Specify)	,,	City or Town, St	rate)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1					
	thin 24	Medical	one) and manner stated.  29b. Sign fure and title of certifier	29c. License number		Date signed (Month, Day, Year)		
	P ≥ P S		Kal -tu H. 2 mi					
	5		30. Name and address of person who completed cause of death (Item 23a) (Type	D0055522	4/	20/2009		
	69)		Robert H.Gerard 1500 Forest Glen Rd.	· ·	20910			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registr	ar	APN 8 3 2009 /2 M Land					

the Medical Examiner must be notified at filed within 72 hours after death with or items 23a Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Modis once.

the

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and funeral director, Director: /

Box 68760.

P.0.

Division of Vital Records,

Prince George Birthplace (State or Foreign Country) 08/04/22 Lancaster, SC 10d. Inside City Limits Largo 1 XYes 2 No Director Md Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 600 Largo Road 20792 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: Black 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Clerk 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillie B. Hall Charlie Reeves မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9805 New Orchard Dr. Largo, MD Harry Clark Walker III Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glenwood Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 □ Removal from State 04/24/09 Washington, DC 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snead Mortuary Service, P.A. 1409 Fairlakes Pl Ste B Mitchellville, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Vear Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ► R/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number April 20,2009 D-18545 and address of person who completed cause of death (Item 23a) (Type, Print) PHillip Wisotsky (12070)Old Lane Centre #207 Waldorf Md 20602

6:07pm<sup>M</sup>

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

22

2009

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day
April 19 2009 **Physician**  $\mathbf{a}^{\mathsf{M}}$ Mary Walker 10:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Largo Prince George's Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 😾 F Aug 17 1915 Director 577-30-9910 93 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location death with the Marylan 10d. Inside City Limits ral", or items 23a or 28a-f show Expriner must be redffled at 1 XYes 2 No Director MD Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **IISA** 20744 12503 Parkton Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐Yes 2X No þ Specify: 3 Widowed 4 ☐ Divorced "natural" Completed er than "natur, 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "r traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) 12th Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Simpson Nancy Aikens ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Depertment of Health ar
Important: If Item 27 is
en, Injury or other trau 12503 Parkton Street, Fort Washington, MD 20744 Larry Walker/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State MD National Cemetery 4/25/2009 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of eral Service 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initic\*ed events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans URETHERAL STONE resultin death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical CHRONIC ANEMIA attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 □ Yes 1 ☐ Yes 2 🙀 No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MD 3 22, 2009 D62116 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEKLIT WORKNEH M.D. 7705 BELLE POINT DRIVE GREENBELT, MARYLAND

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

		_ POF	ite oi Maryianu / L	Department of H		ientai nyg	ierie		
		State Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of L	Jeatn	2. Date of Deat	eg. No. 200	3. time of beauty	
Physici		PHILIP WRO	TEN			Awril		59 0355 an	
/Medic Examin		4a. Facility Name (If not institution, give street	,	4b. City, Town, or	Location of Death		4c. County of I	Death	
		Dorchester Gener			ridge If Under 24 Hrs.	Lo put (Blat	Dorche		
Funeral Director		5. Social Security Number  214-34-7974  6. Sex  1 □ M 2	7. Age (In yrs. last bir	Yrs. If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 4		Birthplace (State or Foreig Country) Maryland	
<b>*</b>	1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limit	
f sho	to	MD Dorcheste	r	Cam	bridge			1 □ Yes <b>2</b> €□ N	
item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 5148 Airey's Road		10f. Zip Code	21613	1	10g. Citizen of What Country?  USA		
ns 23	era	11 Marital Status 12. W	as Decedent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		American Indian,	
l", or Itel xaminer	by Fur	1 ☐ Never Married 2 ☐ Married 1	med Forces? ②Xes 2□No Yes, Give ear or Dates: 1955–59	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	nican, etc.)	Specify:	White, etc. white	
atura cal E	ted	15. Decedent's Education	16a	. Decedent's Usual Occup	ation		16b. Kind of Busin	ess/Industry	
an "n Medi	Completed	(Specify only highest grade com Elementary/Secondary (0-12)	ollege (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most or work d)	ang .		ronoratina	
t, the	S	12		filler	10 Mothor's Nom	o (Eiret Middle I	Maiden Surname)	generating	
arked other than atic event, the N	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Ira G. Wroten				Bromwel:			
marke	P	19a. Informant's Name/Relationship (Type. Pl	rint) 19t	b. Mailing Address (Street				nte, Zip Code)	
27 is mar r trauma		Cecelia Bowers	<i>'</i>	148 Airey's					
othe		20a. Method of Disposition	20b. Place o	of Disposition (Name of ery, crematory or other place	ce)	Date	20c. Location - Cit	y or Town, State	
int: If		1   Burial 2 □ Cremation 3 □ Remov  □ Donation 5 □ Other (Specify)	East N	lew Market Ce	m. 4/2	4/09	East Nev	v Market, MI	
Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee		22. Name and Addre	' T		neral Hor MD 216	_	
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ns that caused the death. Do	not enter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
sician		Immediate Cause (Final disease or condition	RESPIRATO		LURE			Onset and Death	
edical		resulting in death)	Due to (or as a consequence	of):					
miner	_	Sequentially list conditions, b.	PNEUMON						
ısit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	METASTA		V Gi	CANCE	ER		
al-trai	xar	that initiated events c c	Due to (or as a consequence		<u> </u>				
ysicia e buri	dical	d							
ng ph) as th	Medi	IF FEMALE:							
certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant	yes, outcome pf pregnancy □Live birth 2 □ Fetal deat	h 3 Ectopic pregnanc	у		23d. Date of Month	*	
the a	/sic	1 TVes 2 TNo	□Pregnant at time of death □Unknown	5 ☐ Other (specify) _					
ed by detac		Part II. Other significant conditions contribu	ting to death but not resulting	in the underlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death	
sign Ild be	d by					1 □ Y	es 2 □ No 3	☐ Probably 4 ☐ Unkno	
s beer	Completed					24a. Was a		re autopsy findings availa	
te ha	E O					autop: perfor 1 Yes	med? dea	or to completion of cause ath? IYes 2□ No	
otor, p	a)	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only or			
his ce I direc	To B	1 Yes 2 No Hospit	tal: 1 ☑ Inpatient 2 ☐ ER/O	dipatient 3 DOA			ence 6 □Other		
After t unera		1 Natural 5 ☐ Pending		. Time of 28c. Inju No:  M 1 □	ryat rk?  Yes 2 ∐ No	28d. Describe h	ow injury occurred		
25. Was case referred to medical examiner?  1   Yes 2   No						or Rural Route Number,			
neral Di			n: To the best of my knowledg						
To the Fune completely f	edical		On the basis of examination a and manner stated.	and/or investigation, in my	opinion, death occu	arred at the time,	date and place, an	d due to the cause(s)	
E	ž	29b. Signature and title of certifier	111.11	29c. Licens			29d. Date signed (		
<b>P</b> 8	1	1 Y	Tradouth	a DI	6746	>	09/20	12009	
<b>P</b> 8		/ / /		.1					
000		30. Name and address of person who comple Abul Arifuddowla, 1		.1			21601		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03402 State of Maryland / Department of Health and Mental Hygiene Everett Woolford Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day April 27, 2009 Physician/ 1900 hrs **∃** Examiner Everett c County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Dorchester Cambridge **Dorchester General Hospital** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Foreign Maryland 5. Social Security Number **Funeral** Months Days Hours Min. Country) Director Yrs 1 X M 2. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No or 28a-f show or items 23a or 28a-f sho must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 Married 2 V No Yes Black Yes 2 No specify: Specify: f Yes, Give Year Divorced yes I and 2 should be filed within 72 hours after of Health and Mental Hygiene.

If item 27 is marked other than "natural", of the traumatic event, the Medical Examiner 1 Widowed 4 ≥ Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+ filed within 72 3 rave 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Woolford Darah Be 01 (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) MD. Rd. E.N. Market, HOlly QW Ha rris OON Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Baltimore, Removal from State 1 X Burial 2 Cremation 3 6 0 ambr.d Important: Donation 5 Other Specify 22. Name and Address of Facility Home, P. A. 21. Signature of Funeral Service Licensee HENRY Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard follows list only an applications are shock or heard follows list only an applications are shock or heard follows list only an applications are shock or heard follows list only an applications are shock or heard follows list only an applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard follows list only an applications that caused the death. nello StiCambridge, MD.21613 Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death Indical Acute aortic dissection Immediate Cause (Final disease **kamine** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit AMENDED 23a,27, perME, g891 5/7/09 TT Physician/Medical tending physician a X UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown s been signed by the att should be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Yes 2 No 3 Probably 4 V Unknown ğ Records, P. Completed 24b. Were autopsy findings available 24a. Was an has been s prior to completion of cause of autopsy performed? death? 1 🗸 Yes No Yes 2 certificate h 26.Place of Death (Check only one) 25. Was case referred to medical Be Residence 6 Other: examiner? Hospital: 1 ✓ Inpatient 2 Nursing Home 5 ER/Outpatient 3 this ပ 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After Certification: Yes 2 No 1 X Natural Pending Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc

Division of Vital

To the Hospital or Attending Physician: within 24 hours and very To the Funeral Director: A

3

Medical

Suicide

29a. Certifier 1

Homicide

Donna M. Vincenti, MD 31. Date filed (Month, Day, Year, State

29b. Signature and title of certifier

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

**OCME** 

32. Redistrar's Signature

and manner stated

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

**ORIGINAL** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 28, 2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 22 2009 April 23:07 PM Helen S. Ward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Union Hospital of Cecil County E1kton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 □ M 2 F 78 11,1930 Maryland 217-24-0118 Director Aug. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2XXNo Directo Maryland Cecil North East 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 805 Hances Point Road 21901 United States Pages 1 and 2 should be filed within 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 27 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Alexander Essie Nowland ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Ward / Spouse 805 Hances Point Road, North East, Maryland 21901 20b. Place of Disposition (Name of North East Methodist Cemetery 20a. Method of Disposition April Pat 25, 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any Injury or ot once. 1 N Burial 2 Cremation 3 Removal from State North East, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final mall Bowel **Physician** Obstruction disease or condition resulting in death) /Medical Due to (or as a consequence of) 2 weeks Examiner dhesions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Fibrilation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an performed 2 200 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 00065013 2 Fuller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 204 S.S+EIKton MD Z1921 MD 31. Date filed (Month, Day, Year)

APR 2 3 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Ye ar **Physician** AM Carol Christine Wright 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMIC SAUSBUR REGIONAL If Under 1 Year | If Under 24 Hrs Social Security Numbel 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) Days 1 □ M 2 🖾 F Months Hours Min. 58 Director 217-54-6069 New York Dec. 19, 1950 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 27 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the fredict Evantary. The fredict at Director 1 ☐ Yes 2 X No Wicomico Salisbury MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21804 U.S.A. 6932 Zion Church Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2XXXVo Specify \$ Specify: white 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) childcare 12 caregiver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor D. Rains Jesse Medeiros 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any Injury or other trau once. 305 E. Lillian Street Hebron, MD 21830 Warner Eric Wright (Son) altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Melson's Cemetery April 22, 2009 Delmar, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Delmar, DE 19940 Immediate Cause (Final Physician Spock disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to in media cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed tran Due to (or as a consequence of) burial-1 Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? nas autopsy page performed 2 🗷 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide 29a. Certifier 1 🛫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. CARROLL

32. Registrar's Signatur

29d. Date signed (Month, Day, Year)

4-21-2009

ST. SAUSBURY, MO

09-03183 Charles A. Williams	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene	0
	1- For State of Maryland / Department of Health and Mental Hygiene 2009 146  Registrer Registrer	9
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  Charles Avaré  Williams Jr.  2. Date of Death Month Day April 21, 2009  4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death	
Funeral	Peninsula Regional Medical Center  Salisbury  Wicomico  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or	4
Director	218-84-7711 1XM 2 F 34 Yrs. Months Days Hours Min. 10/27/74 Foreign Country) Md	
Aaryland 28a-f show any 1 at once. ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ves 2 Inc	
r death with the Maryland or items 23a or 23a-f sh rmust be notified at onc Funeral Director	10e. Street and Number  27548 Log Cabin Road  10f. Zip Code  10g. Citizen of What Country?  United State  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	2
r death w or items must be	1 Never Married 2 Married Armed Forces? 1 Yes 2 No  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.	
"natural", Ex.miner	3 Widowed 4 Divorced of Specify: 1 Yes 2 No specify: Spec	$\dashv$
0036 within 72 ene. er than Medical	Elementary/Secondary (0-12) College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  Truck Driver  18. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
21215-Culd be filed volumental Hyginarked oth cevent, the To Be Cc	17. Father's Name (First, Middle, Last) Charle and Charle Williams SR. GINNCENE D. Butler	
MD 2121 d 2 should be f lth and Mental n 27 is markee aumatic event,	19a, Informant's Name/Relationship (Type, Print) (M6 ther) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  SINN EENE D. Williams 2548 Log Cabin Rd. Salls by 14. Md 21861	1
Baltimore, MI permit. Pages 1 and 2 s Department of Heath as Important: If item 27 Injury or other traum	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, cremation 2 Cremation 3 Removal from State crematory or other place)  20c. Location City or Town, State	
Baltimore permit. Pages 1 a Department of He Important: If it	4 Donation 5 Other Specify: Wesley Umc Cem. 4-25-09 Vienna, mg  21-Signature of Funeral Service Licensee  22. Name and Address of Facility  22. Name and Address of Facility  21. Signature of Funeral Service Licensee	$\dashv$
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva	ai ai
Physician /Medical	failure. List only one cause on seach line.  Immediate Cause (Final disease  a. Multiple Gunshot Wounds	
( xaminer	or condition resulting in death)  Due to (or as a consequence of):	
iner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of): cause. Enter Underlying Cause	٦
kecuted and - transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
be execut ician and urial - trai	UNPENDED AMENDED	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfedical Certification: To Be Completed by Physician/Medical E.	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 23d. Date of delivery Month Day Year	
ords, P.O. Box w requires that the deatl s been signed by the att should be detached for oleted by Physi		$\dashv$
S, P.( uires tha n signed Id be deti		_
tal Records, cinn: The law require certificate has been si ector, page 2 should bb Be Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No	
Vital Rec ysiciau: The lihis certificate director, page	25. Was case referred to medical examiner? Hospital: I legation 2. A ED/Outpatient 3 DOA Other: Nursing Home 5 Regidence 6 Other:	╕
sion of Vi wtending Physi death. ctor: After this y the funeral dir cation: To	27 Marco of Darks	7
Division of N To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After i completely filled in by the funeral ledical Certification: T	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Single Family Home 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cit or Town, State) 722 South Park Drive, Salisbury, MD	ty
To the llos within 24 h To the Fun completely	23a. Gettiller 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To with To com	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	_
O mil	Carol Hellar O.C.M.E. April 21, 2009	$\perp$
0.	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	A P D D D D D D D D D D D D D D D D D D	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician trances /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 50/136414 Alcomico If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1□M 2**X**F 220-24-1244 9-14 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Middeal Exercitive must be notified at 1 ☐ Yes 2 ☐ No Director olombia MDHou 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 21045 tickor L09 ( 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) House Keepin Morker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lorene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Hnnette Circle 21845 Hickory olombia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) no UMC Cemetro 4,25,2009 21. Signature of Funeral Service Licensee Stret bella any 21801 MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Verhouse **Physician** /Medical Due to (or as a consequence of) Examiner treed & Point shusking Sal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Live to for as a consciouence of Examiner sician and burial-transit The law requires that the death certificate be executed TD Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical attending pi IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş Enypho 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown JULANTE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 2 🗆 No 1 □ Yes 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours are: \_\_\_\_ To the Funeral Director. Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

6 mg

State Registrar 31. Date filed (Month, Day, Year)

SUDDING

29b. Signature and title of certifier

Fegistrar's Signature 32.

and manner stated.

fress of person who completed cause of death (Item 23a) (Type, Print) 20

29c. License number

9069

29d. Date signed (Month, Day, Year)

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			1 - For State Registrar	State of Maryland /		rtment of Heatificate of De			iene <sub>eg. No.</sub> 2009	9 14699
Pł	nysicia	ın	1. Decedent's Name (First, Middle, Last) Clarence Richard Br	anch. Jr.				2. Date of Deat	-	3. Time of Death
· •	Medic xamin		4a. Facility Name (If not institution, give streets) 3504 Summit Drive			4b. City, Town, or Lo	cation of Death		4c. County of Dea	ath
	neral ector		21, 30 1203	7. Age (In yrs. last 89	birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02/23/1	Year) 9. Bi C New	rthplace (State or Foreign ountry) Jersey
Maryland	The dark	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Prince Geo.	rges Rive	own or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the	at be not	al Director	10e. Street and Number 6405 57th Avenue	- 1		10f. Zip Code 20737		1	0g. Citizen of What C	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hytiene.	Staminer mu	by Funeral	11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates:	11	Vas Decedent of Hispa i Yes, specify Cuban, I Yes 2 □ No S	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
within 72 horiene.	he Medical F	Completed	15. Decedent's Educat (Specify only highest grade c	ompleted) College (1-4or 5+)	(Give I life. D	lent's Usual Occupation kind of work done duri DO NOT use retired) r Fabricat	ng most of work	ing	16b. Kind of Business Welding	s/Industry
should be filed and Mental Hygi	tic event,	To Be Co	17. Father's Name (First, Middle, Last) Clarence Branch							unknown
and 2 shou ealth and N	er traumat		19a. Informant's Name/Relationship (Type: Gary Branch/Son	Print) 1		g Address (Street and			r, City or Town, State,	Zip Code)
permit. Pages 1 a Department of He	ury or othe		20a. Method of Disposition 1 □ Burial 2 💆 Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	ceme	of Dispos etery, crem	sition (Name of natory or other place) tion Service:		Date	20c. Location - City o Hanover, N	
permit. Departr	any inju		21. Signature of Funeral Service Licensee						emation Ser N, Hanover	cvices c, MD 21076
Physi			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one disease or condition resulting in death)	cause on each line.		er the mode of dying, s			est,	Approximate Interval Between Onset and Death
Exam		<u>.</u>		Due to (or as a consequence	ce of):					
ate be executed	the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence						
ath certifi	or use as	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of d	elivery Day Year
equires that	bed	by P	Part II. Other significant conditions contri	outing to death but not resulting	g in the un	derlying cause given i	n Part I.	23e. Did to		to the cause of death?  Probably 4 Unknown
The law requ	ral director, page 2 should	Completed						24a. Was a autops perform	sy prior to med? death?	autopsy findings available completion of cause of
hysician his certifi	director	To Be	25. Was case referred to medical examiner? 1 \( \text{Yes} \) 2 \( \text{Yes} \) 1 \( \text{Yes} \) 2 \( \text{Yes} \) 1 \( \text{Yes} \) 1 \( \text{Yes} \) 1 \( \text{Yes} \) 2 \( \text{Yes} \) 1 \( \text{Yes} \) 2 \( \text{Yes} \) 1 \( \te	pital: 1 ☐ Inpatient 2 ☐ ER/	Outpatien	Other		h <i>(Check only or</i> ome 5 ⊠Resid	ne) ence 6  ☐ Other (Sp	ecify)
Attending Pl death.	90	Certification:	1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day, Year) 28l 28e. Place of Injury - At home, building, etc. (Specify)	o. Time of Injury		s 2□No	28f. Location (S	ow injury occurred	Rural Route Number,
pital or /	filled in b			building, etc. (Specify)  ian: To the best of my knowled				City or Tow	n, State)	
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A	completely	Medical		On the basis of examination and manner stated.			ion, death occur	red at the time, o		ue to the cause(s)
E » F	8		Julius Ce	1		D 25	979		4/28/0	9
			30. Name and address of person who comp	out, no	5 to-		Luc 1	· cee	\$002 6	7070c
R	Stat egistra		MAY 0 7 2009	32. Registrar's Signature	Back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5,perf 2891 5/18/09 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 9 Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** oczkowski 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 1777/-If Under 24 Hrs. ff Under 9. Birthplace (State or Foreign Country) (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** 1□ M 2世 F Months Days Hours Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Mydical Examinat must here . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BIEL EANNE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 2829 /46DSON SKARDA F 3/7/10 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease. shock, or heart failure. List only one cause on \_ach line Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical Due to (or as consequence of): Examiner eimi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown this certificate has been signed I al director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 × nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 🗷 No 1 □ Yes 2 🗆 No æ 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Matural 5 ☐ Pending investigation 1 □Yes 2 No 2 □ Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature 30. Name and address of person who complete cause of death (Item 23a) (Type DOSal la 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Ye aı Physician 5, 2009 30 PM May /Medical County of Dea Examiner 8. Date of Birth (Month, Day, Year) 09/14/1918 **Funeral** Months Days Hours Virginia 90 214-24-8797 Director Usual Residence of Decedent Department of Health and Mental Hygiene. Indepartment of Health and Mental Hygiene. If item 27 is marked other than "nature." 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 ☐ Yes 2 No Director Maryland Anne Arundel Co. Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1036 Minnetonka Road 21144 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Be Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 yrs. Foster Parent / Homemaker Anne Arundel County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mageline Rebecca Kendrick Mullins Joseph Ray ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. William J. White / 127 Second Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park 05/08/2009 Elkridge, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atrial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ON Due to (or as a consequence of) Physician/Medical the funeral director, page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 No Year Month Day P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe as 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-05,05,2009. 63726

Registrar

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32. Registrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** P M Edward Bailev April 24, 2009 11:50 Stewart /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 14714 Carson Drive Burtonsville 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) November 23, 1935 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 X M 2 □ F 162-26-3815 73 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Exer in strings by notified at Director 1 XYes 2 No or 28a-f Maryland Montgomery Burtonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 14714 Carson Drive 20866 death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life 100 NOT use retired) Super Visory Construction 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Washington Metroplitan than " Elementary/Secondary (0-12) College (1-4or 5+) Area Transit Authority Field Coordinator is marked other t 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If I lem 27 is marked oth any Injury or other traumatic event 17 Father's Name (First, Middle, Last) Be ဂ္ဂ Stewart Sylvester Bailey Grace F. Schmuck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Bailey- wife 14714 Carson Drive, Burtonsville, MD 20866 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 5/4/09 Burtonsville, Maryland 22. Name and Address of Facility Fleck Funeral Home. 21. Signature of Funeral Service Licensee M01254 V 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 6 months Lung Cancer /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease 10 years Sequentially list conditions, cause (Disease or injury that initiated events resulting in death) Last Que to for as a nonsequence of) certificate be executed Exami and Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Por Month Day Year 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown 9 Unknown ۵, signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ pe 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Physiclan: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation 1 X Naturai death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 □Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43237 April 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong, M.D., 14201 Laurel Park Drive, Ste 102, Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 07 2009 Registrar

			1 - For State Registrar	State of Marylan		ment of F			giene Reg. No.	009	14703
	Physici	an	1. Decedent's Name (First, Middle, Last)		TP			2. Date of De Month	ath Day	2009	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	SAILEY, Street and number) NUTSING+R	ehah 1	b. City, Town, o				ounty of Death	<del></del>
	Funeral Director		Social Security Number 6. S	7. Age (In yrs.		f Under 1 Year Months Days	If Under 24 Hours		th ly, Year)	9. Birth	place (State or Foreign ntry) ansas
	ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Local	ion					10d. Inside City Limits
	Sa-f eh	ctor	MD n/a		Balti				10.000	(14)	1 XYes 2 No
	with ti	Dire	10e. Street and Number 3912 Duvall Ave.			10f. Zip Code 212	16			on of What Cou JSA	ntry?
	deeth	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Wa			? (Specify Yes or No Puerto Rican, etc.)		I. Race - Ameri Black, White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23e or 28e-f e-how entry injury or other treumatic event. The Medical Examiner must be notified at anothe.	Completed by Funeral Director	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Yes 2 No	Specify:	oono maan, oto.y		necify:	ack
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	Sta	te	30. Nime and address of person who compared to the state of the state	32. Registrar's Signa	ature						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . 2009 April 21, 2:00 AMM Doris M. Baumiller 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, July 30, 5. Social Security Number 7. Age (In yrs. last birthday) Days Year) 927 Months 1 □ M 2 🗓 F Maryland 81 220-22-8243 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes & □ No MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 204 E. Joppa Road #1102 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify white Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ó housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Thomas Boone Mabel Alverta Gilland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kimberly Howell-McLean 881 Century Street Hampstead, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State 21. Signature of Lineral Service wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on such line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) e Kemin Due to (or as a consequence of): Sequentially list conditions, living cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, attending physician

**Physician** 

/Medical Examiner Examine dical To the Hospital or Attending Physician: within 24 hours after cleath.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Eventhal in the motified at

Baltimore, Maryland 21215-0036

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☑ No 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	eath (Check only one)  Home 5 □ Residence 6 Ø Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of lnjury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred
1   Alatural 5   Pending 2   Accident investigation 3   Suicide 6   Could not be 4   Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occurred at the time, date and pla iner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.	
29b. Signature and title of certifier	29c. License number	29d. Date signed (Mgnth, Day, Year)

DHMH 17 Rev 1/2001

State Registrar nd address of person who completed cause of death (frem 23a) (Type, Print)

Year)

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Physici /Medi Exami

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, its Medical Evantrac must be routlised and once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	For State Of 1	viai yiaila / D	•	te of Deal		1	Reg. No	2009	14705	
	1. Decedent's Name (First, Middle, Last)					2. Date of Dea			3. Time of Death	
an :ai	David Broitman					May 4		009	11:05 Å	
er	4a. Facility Name (If not institution, give street and numb	er)	4b. City	, Town, or Locati	ion of Death		40	. County of Deatl	n	
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	5. Social Security Number 6. Sex 7.	Age (In yrs. last birt	Months		der 24 Hrs. Irs Min.	8. Date of Birl (Month, Da April	th Year	9. Birti	hplace (State or Foreign untry)	
	1/5-56-/523	70	rs.			April	۷,	1939 UKT	aine	
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Ş	11. Marital Status  1 □ Never Married 2 ▼ Married 1 □ Yes 2	s?	If Yes, sp	edent of Hispanic ecify Cuban, Mex	cican, Puerto F	Rican, etc.)		Black, White	e, etc.	
þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give	_	1 □Yes	2⊠No Spe	cify:			Specify: Whi	te	
Completed by Funeral Director	15. Decedent's Education	16a	Decedent's Us	ual Occupation			16b. I	Kind of Business/	Industry	
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To E	Mordko Broitman				Dina	a Gonop	ols	kaya		
ľ	19a. Informant's Name/Relationship (Type. Print)							or Town, State, 2		
	Laura Broitman/ Wife				, #1107	Rocky			and 20850	
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	21. Signature of Funeral Service Licenses		22. Name	and Address of Fa	acility Robe	ert A.	Pum	phrey Fu	neral Home/	
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ete	Dishetes					24a. Was	an	24h Were a	utopsy findings available	
ם	Diabetes					auto	psy ormed?	prior to death?	completion of cause of	
						1 ☐ Yes		lo 1 □ Yes	s 2 No	
Be	25. Was case referred to medical examiner?			Othor	Place of Death			о По <del>ль (</del> о		
유		natient 2 ER/Ou	itpatient 3 □	DOA 4L		me 5 ∐ Hes 28d. Describe		6 ☐ Other (Spe	ecity)	
io	1 ☑ Natural 5 ☐ Pending (Month,	Day, Year)	njury M	28c. Injury at Work? 1 □ Yes				,		
lica	Z L Accident	Injury - At home, fa				28f. Location	(Street	and Number or R	ural Route Number,	
erti	4 Homicide determined building	Injury - At home, fa , etc. <i>(Specify)</i>	, ,	,,		City or To	wn, Sta	ate)		
C	29a. Certifier 1덫 Certifying Physician: To the b	est of my knowledge	e, death occurr	ed at the time, da	ate and place,	and due to the	e cause	(s) and manner a	as stated.	
Medical Certification: To	(Check only 2 Medical Examiner: On the bas one) and manne		nd/or investigati	on, in my opinion	n, death occurr	red at the time	, date a	and place, and du	e to the cause(s)	
Me	29b. Signature and tipe of certifier			29c. License num			29d. [	Date signed (Mon	th, Day, Year)	
	I for a s	adalishon s	(ivs)	D6531	2		5	14109		
	30. Name and address of person who completed cause									
	Sudarshan Siva, M.D. 8	600 Old C	eorget	own Road	, Beth	esda, N	lary	land 208	314	
ate	31. Date filed (Month, Day, Year) 32. Reg	jistrar's Signature								

St

Physic /Med Exami

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

**Physician** /Medical

	1 - State Registrar			-	Ce	rtificate of l	Death	F	Reg. No.	UUS	14	100
sician	1. Decedent's Name (	First, Middle, L	ast)			01-		2. Date of Dea Month	Day	Year	3. Time o	Α
edical	Robert  4a. Facility Name (If no	ot institution ai	ve street and nur	Lee		4b. City, Town, or	yton	May	0.5 4c. Cour	2009	06.0	.C P
miner	Manor Ca	re Nu				Tov	son		,0.002	by of Death Ba <b>lti</b>	more	
al or	5. Social Security Num 219–26–85		Sex 1∏XM 2□F	7. Age (In yrs. 67	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, Year)	9. Birthpl Count	ace (State try) MD	or Foreign
To Be Completed by Funeral Director	Usual Residence of De 10a. State 10	ocedent 0b. County		10c. Cit	y, Town or Lo	ocation	-			10	d. Inside C	ity Limits
tor	MD	NA		I	Balti	more					X☐Yes	2 🗌 No
Direc	10e. Street and Number	er				10f. Zip Code				f What Count	ry?	
eral	3524 Manc	heste				212				S.A.		
<b>Funeral Director</b>	11. Marital Status 1 □ Never Married	2□ Married	Armed Fo			Was Decedent of H If Yes, specify Cuba	ın, Mexican, Puer	to Rican, etc.)	14. H	ace - America lack, White, e		
d by	3X Widowed 4		If Yes, Giv Year or Da	/e		1 □Yes 2 XNo	Specify:		Spec	eify: B1	ack	
Completed	(Specify	5. Decedent's E only highest gi	ducation ade completed)		16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wo	rking	16b. Kind of	Business/Ind	ustry	
ошо	Elementary/Seconda	_ * '	College (1	-4or 5+)		urity Gu			Kerna	n Hos	pita	1
BeC	17. Father's Name (Fin		t)				18. Mother's Na	me (First, Middle,		ame)		
일	Walter Fa	Х					Aleace	Clayto	n 			
	19a. Informant's Name				1	ng Address (Street) 7 Bowman						2120
	Elisa Cla	_	Daugnte					Dr Ive,		n - City or To		
	Burial 2 0 4 Donation 5	Oremation 3 [ □Other <i>(Spec</i>	ify)		rriso	nsition (Name of matory or other place n Forest	Vet 5	/13/09		ngs Mi		Md
	21. Signature of Fune	ral Service Lice	ensee	ŷΛ <sub>ŧ</sub>	M 4	2. Name and Addre arch F/1 300 Waba	i West ash Ave	, Balti	.more,	Md 2	21215	
1	23a. Part . Enter the	disease, or cor ailure. List only	nplications that c	used the death	h. Do not en	ter the mode of dyir	ıg, such as cardia	c or respiratory ar	rest,		Approxima Interval Be	tween
1	Immediate Cause (Fir		. A1.	DS						i	Onset and	Death Week
	esulting in death)	•	Due to (	or as a consequ	uence of):							
e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Listers or A run)											
Examiner	cause. Enter Underlyi Cause (Lisease of inju- that initiated events	ng ury	C							- 44		
	resulting in death) Las	t	Due to (	or as a consequ	uence of):							
Medical		•	d									
	IF FEMALE:	ognost.	23c. If yes, out	come of pregna	incy				234 [	Date of delive	rv	
iciai	23b. Was decedent pr in the past 12 mo 1 Tes 2 N	onths?	4 🗌 Pregr	oirth 2 Teta nant at time of d		☐ Ectopic pregnanc ☐ Other (specify) _	у				-	Year
Physician	9 🗆 Unknown		9 □ Unkn									
by	Part II. Other significa	int conditions	contributing to de	eath but not resu	ulting in the u	inderlying cause give	en in Part I.		id tobacco use contribute to the cause of death?  ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown			
eted												
Completed	-							24a. Was a autop perfor	sy med?	<ul> <li>b. Were autor prior to cor death?</li> </ul>	npletion of	cause of
O	25. Was case referred	to medical	1				26. Place of De	1 □Yes ath (Check only or	2 No	1 □Yes	2. No	
<u>0</u>	examiner? 1 □ Yes 2 No		Hospital: 1 □ I	npatient 2 🗆	ER/Outpatie	nt 3 DOA Oth		Home 5 ☐ Resid		Other (Specify	<i>'</i> )	
 0	27. Manner of Death 1 Natural	5 ☐ Pending	28a. Date (Mont	of Injury th, Day, Year)	28b. Time o	Worl	<b>ί?</b>	28d. Describe h	ow injury occ	urred		
Certification: T	2 Accident	investigation 6 □Could not I	ne I	of Injury At he	ome form of		Yes 2□No	20f Location (C	Name at a mod 84.	mhos as Bum	l Davies Alve	mha r
ertit	4 Homicide	determined	buildii	ng, etc. (Specif	y)	reet, factory, office		28f. Location (S City or Tow	n, State)	mper or Hura	Houte Nur	riber,
Medical C	29a. Certifier 1 (Check only 2 one)	Certifying P	miner: On the ba	best of my kno asis of examina ner stated.	wledge, deat	th occurred at the tin	me, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner as si e, and due to	tated. the cause(	s)
Med	29b. Signature and title	e of certifier	and man	iei stated.		29c. Licens	e number		29d. Date sig	ned (Month, I	Day, Year)	
	▶ Kith	da				DOC	5928	3	Mary	05	20	09
	30. Name and address	of pe son who	completed caus	e of death (Item	n 23a) (Type,	Print)			(100)	1.00	-	
	Dr. Addo	0 12 1 -	00 D	and the second of the second	Acres .	treet, I	owson,	Maryla	nd 2	1204		
ite 'ar	31. Date filed (Month,	rear)	000	gistrar's Signa		9						
2001	*17		009	we ,	8. p	ares						
						BINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Kosaria May 2, 2009 8:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner Font Hill Assisted Living Ellicott City Howard 8. Date of Birth (Month, Day, Year) Aug. 18, 1 9. Birthplace (State or Foreign Country)
Italy 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Min. Hours 1 □ M 2 🖫 F 95 Director 218-36-3767 1913 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "tedical Examinar is ust be notified at Director 1 ☐ Yes 2 K No Howard Ellicott City Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2914 Thornbrook Road 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. 2 If Yes, Give Year or Dates: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Rosalia Garbo Giuseppi Testa ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank J. Cangelosi Son 2914 Thornbrook Road; Ellicott City, MD 21042 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 5/7/2009 Pikesville, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Servicé Licerses 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Linkrown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Unknow Sequentially list conditions, if any, leading to immediate cause cause or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year P.O. I 1 ☐ Yes 2 Z No 9 ☐ Unknown 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 225No certificate 1 □ Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation after death.

Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar
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30. Name and address of person

Year)

31. Date filed (Month, Day,

CRNA

who completed cause of death (Item 23a) (Type, Print)

			1 - For Amend Item Registrar	Sjate of Ma	ryland 6	Pegg Cert	7079094k	lealth an Death	id Mental H	ygiene Reg. No.	2009	3 14	708
			Decedent's Name (First, Middle, Last)						2. Date of D	eath		3. Time o	of Death
	Physici /Medio		John Henry C	lick					Month April	15	2009	9:30	PM
بدلا المواتات	Examin	er	4a. Facility Name (If not institution, give s	· ·			4b. City, Town, o	Location of D	eath	4c.	County of Dea	ith	
			Frederick Men  5. Social Security Numberlink 6. Sex		spital (In yrs. last bi	irthday)	If Under 1 Year	rederi		irth	Frede	erick thplace (State	or Foreign
	Funeral Director			IM OFF	38	Yrs.	Months Days		Min. (Month, I	Dav. Year)	C	yland	or r oroigir
	0		Usual Residence of Decedent									· · · · · · · · · · · · · · · · · · ·	
	arylar show	5	10a. State 10b. County		10c. City, Tov		ation					10d. Inside C	City Limits S 27 No
	the M	Director	MD Frederick  10e. Street and Number		Freder	cick	10f. Zip Code			10g Citi	zen of What C		
:	within 72 hours after death with the Maryland lene. Than "natural", or items 23a or 28a-f show he Medical Examiner mant be motified at	Ē	355 Montevue Lane					21702		Tog. Oil	USA	ourkry.	
:	death ms 2;	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Decedent of H	ispanic Origin	? (Specify Yes or N	lo-	14. Race - Am		
စ္တ	or ite		1 Never Married 2 Married	Armed Forces? 1 □Yes 24 N If Yes, Give	lo		Tes, specily Cuba □Yes 2XINo	Specify:	uerto Rican, etc.)		Black, White	<sub>ve, etc.</sub> √hite	
21215-0036	ural",	Completed by	3 Widowed 4 Divorced	Year or Dates:	40.					10h 1/3			
-5	n 72 n "nat	plete	15. Decedent's Educ (Specify only highest grade	e completed)		(Give ki	ent's Usual Occup ind of work done o O NOT use retired	during most of	working	160. KI	nd of Business	industry	
212	d with giene rr than	mo;	Elementary/Secondary (0-12) 5	College (1-4or 5+	+)		s statio	*	ndent		automot	tive	
ם ו	al Hy	Be	17. Father's Name (First, Middle, Last)	_					Name (First, Middi				
ya ya	ould b	ပု	Frank Robert Cli						e Viola				
Maryland	nd 2 sh alth and 27 Is m ir traum		19a. Informant's Name/Relationship (Type Dawn Hahn/niece	oe. Print)					or Rural Route Num Road Fred				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Departit. Pages 1 and 2 should be filed within 12 hours after 71 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Extrainment in the infilted a once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rid and Donation 5 ☑ Other (Specify)		20b. Place of cernete	of Disposi ery, crema	tion (Name of atory or other plac	ce)	Date	20c. Lo	cation - City or	Town, State	
Balt	permit. Departr Importa any Inju		21. Signature of Funeral Service Licenses	Pale hit	ctor		Name and Addre ate Anat ltimore,	-	ard 655 W	. Bal	timore	Street	
	hysician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Ca. se (Final disease or con lion resulting in death)	cations that caused e cause on each line	e.		_		rdiac or respiratory		IRE	Approxima Interval Be Onset and	tte etween Death
	/Medical Examiner		Toolaning in docum	Due to (or as a	consequence							Days	
	ed sit	iner	Sequentially list conditions, if any, learning to himediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	s oune equenee	บ):							
ó	Icate be executed physician and sthe burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence	of):							
8760,	cate be shysicia the bur	dical	<b>C</b> d	·									
9 X	attending p	/Me	IF FEMALE:	3c. If yes, outcome of	of pregnancy						23d. Date of de	li rami	
O. Box	rife faw requires that the death certain ate has been signed by the attending I page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗀 Fetal deat		Ectopic pregnand Other (specify) _	y			Month	Day	Year
o,	signed b	by Pt	Part II. Other significant conditions con	tributing to death bu	t not resulting	in the unc	lerlying cause giv	en in Part I.	23e. Dio	i tobacco ι	ise contribute t	to the cause of	death?
ğ	s been signatured by	edt							1	Yes 2	□No 3□F	Probably 4 🗗	Unknown
၁၁	has be	Completed							24a. Wa	s an opsy	24b. Were a	utopsy findings completion of	available cause of
E :	cate cate	Con								formed? 2 ☑No	death? 1 □ Ye	s 2□No	
Vita	certifi ector,	Be	25. Was case referred to medical examiner?	ospital:			3 🗆 DOA Oth		Death (Check only	one)			
ō	uning Frigstelan. The h. After this certificate h. funeral director, page	To	1 Yes 2 140	1 Inpatier 28a. Date of Injur	nt 2 ER/O	utpatient Time of	3 DOA 28c. Injur	4 🗀 Nursii	ng Home 5 ☐ Re			ecify)	
o	ith. :: Afte e fune	ation	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,		Injury	Wor	Yes 2 □ No	200. 2000.	. Describe how injury occurred			
Division of Vital Records,	ours after death	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, fa . (Specify)	arm, stree	et, factory, office			(Street an own, State		Rural Route Nui	mber,
1	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, is	Medical (	29a. Certifier 1	ner: On the basis of and manner stat	examination a ted.	nd/or inve	estigation, in my o	pinion, death	occurred at the tim-	e, date and	i place, and du	e to the cause	
1	vith To t	Σ	29b. Signature and title of confifier				29c. Licens	e number		29d. Da	te signed (Mon	nth, Day, Year)	
			· All	MD			200	6141	0	FIF	RIL,	16,20	09
			30. Name and address of person who could be seen and address of person address of person address of person and address of person addre	mpleted cause of de	eath (Item 23a)	(Type, P	rint)	use -	O -H4,	Ens	=DED	ele n	ил
F	Sta	te	31. Date filed (MMIA Pay (Yary) 2009	30 Registra	r's Signature	hores	Kan 170		114,	, , ~	101KI	-,-, ,	'1)
	Registr		MAI U ( ZUU)	- Carona	Jo.	The							

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hbargu 02 MIR 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOWA1 AlumbiA If Under 1 Year | If Under 24 Hrs. | Hours | Min. eneIN 8. Date of Birth (Month, Day, Year, May 16, 1943) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 586-62-1296 65 Philippines Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Illimportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Item 1000 in the many injury or other traumatic event, If the Item 1000 in the matter must be notified at once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director Columbia Maryland Howard 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? 10716 Bridlerein Terrace U.S.A. 21045 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2**x** No Specify: Specify: Filipino 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Mechanical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Servando Caballes Enriqueta Abarquez ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings Mills, Maryland 21117 Lynnette Alban (Daughter) 719 Windhill Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5-8-2009 Columbia Memorial Park Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 21. Signature of Funeral Service License 5555 Twin KNolls Road Columbia, Maryland 21045 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CALOUASULA Physician 10 Atherosch disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. ER/Outpatient 3 □ DOA Certification: To 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ✓ Natural 2 ☐ Accident 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifie 29d. Date signed (Month, Day, Year) edula Columbia, who completed cause of death (Item 23a) (Type, Print) no Nd

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5&8 SPAE ANABOA (\$894) ANA (\$100) ANABOA (\$10

4a. Facility Name (If not institution, give street and number)  Manor Care Roland Park  Funeral Director  5. Secial Security Number 215-52-2467  Usual Residence of Decedent  4a. Facility Name (If not institution, give street and number)  Manor Care Roland Park  Baltimore  If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	May 7, 1	Day Year 2009  4c. County of Death	nplace (State or Foreign
Medical Examiner   4a. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death	s <b>Acarrát B</b> irti <b>0</b> (Month, Day, May 7, 1	4c. County of Death  1 1934 9. Birth Year)  9. Birth Cou	nplace (State or Foreign
Manor Care Roland Park  Funeral Director  Section Security Number 215-52-2467  Usual Residence of Decedent  Manor Care Roland Park  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  7. Age (In yrs. last birthday) Onder 1 Year If Under 24 Hrs. Months Days Hours Min.	May 7, 1	1 1934 9. Birth Year) Flor	nplace (State or Foreign intry)
Director  Usual Residence of Decedent  Director  Usual Residence of Decedent	May 7, 1	1 1934 9. Birth Year) Cou 1937 Flor	nplace (State or Foreign untry)
0	10,		ida
	10		10d. Inside City Limits
A Baltimore Reisterstown	10		1 □ Yes 2X□ No
MD Baltimore Reisterstown  10e. Street and Number 12021 Reisterstown Road 21136		g. Citizen of What Cou USA	untry?
10c. Street and Number   10c. Street and Num	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: <b>b1</b>	, etc.
To the state of th	ing 16	6b. Kind of Business/I	ŕ
The state   Specify   Sp	(First, Middle, Ma	post officalden Surname)	unk
The Notice of Park Park Park Park Park Park Park Park			
20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 MOther (Specify) in state		0c. Location - City or T	
21. Signature of Ronal Ed es icen Wade, Director State and Attenty a Board Baltimore, MD 2120:		Baltimore	Street
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physician /Medical Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):			
Examiner  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
per post of the control of the contr			
Special Companies   Spec		23d. Date of deli Month	ivery Day Year
So the part is so that it is the part is so that is the part		acco use contribute to	
OLOS A transport of the part o	24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
Signature of the second of the			
O 1   Yes 2   Mo	me 5  Resider 28d. Describe hov	nce 6 Other (Spec w injury occurred	oify)
E SEE E TOTALINGUE	28f. Location (Stre City or Town,	eet and Number or Ru , State)	ıral Route Number,
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only (C	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
29b. Signature and title of certifier  29c. License number  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Par, Year)  32. Registrar's Standards	29	Od. Date signed (Month	h, Day, Year)
30. Narrie and address of person who completed cause of death (Item 23a) (Type, Print)	1 lond	1 110'	21236
State 31. Date filed (Manth, Par, Year) 32. Registrar's Sanature  Begistrar	- ~~	· FVIP	-1009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:38 AM DOROTHY JANE CAHN Ma 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner N/A UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 1 □ M 2 X F Months Days Hours Min 01/30/1920 89 218-18-7907 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Evention or must be inclined at 28a-f show 1 X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 830 W. 40TH STREET 21211 Funeral 72 hours after death 14. Race - American Indian, Black, White, etc. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify: WHITE þ Specify 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 should be filed w h and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STEIN BAER AUGUSTA ABRAHAM ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 9708 SW QUAIL POST ROAD, PORTLAND, OR 97219 TERRY DALSEMER / DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 Cremation 3 Removal from State 05/06/2009 HEBREW FRIENDSHIP BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt Lei 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis days disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Due to (or as consequence of): Vulgaris Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Ye ar 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 2 certificate 1 ☐ Yes 2 ☐ No 1 □Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c I dire Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🛮 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 29a, Certifier 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 3, 2009

State Registrar Raymond

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Azab, M.D. Union Memorial Hospital, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 - For State Registrar

Division of Vital Records, P.O. Box 68760,

	Physic	ian	1. Decedent's Name (First, Middle, Las					2. Date of D	Day	Year	3. Time of Death
	Physic /Medi		RUTH DEMSI	EY CO	HEN			MAY	5 2009	)	8:10 A M
	Exami	ner	4a. Facility Name (If not institution, give HOSPICE OF BALT	IMORE GILCHRIS		4b. City, Town, o			BALT	y of Death	
н	Funeral		5. Social Security Number 6. St 293-07-3952		last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1920	9. Birthp	olace (State or Foreigr OHIO
	Director		Usual Residence of Decedent		,0			1101 10	, 1920		01110
	ylanc		10a. State 10b. County	10c. City	y, Town or Loc	cation				1	10d. Inside City Limits
	e Ma	cto	MD BALT	IMORE	OWIN	GS MIL	LS				1 □Yes 2 No
	ith th	Die	10e. Street and Number	AV //110		10f. Zip Code	-		10g. Citizen of		ntry?
	sath v	Funeral Director	3440 ASSOCIATED W	12. Was Decedent Ever in U.	6 112 1	2111		Coordy Voc or N	0 14 Pc	USA ace - Americ	an Indian
"	fter de	Ξ	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?		Vas Decedent of F f Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)	Bla	ack, White,	
036	ours a	by	3 ∰ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	∐Yes 2 No	Specify:		Speci	ify:	VHITE
2-0	72 hc 'natur	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	i (Give i	lent's Usual Occup	during most of wi	orking	16b. Kind of 8	Business/In	dustry
21215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Madical Evair item? ust be recitived at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	OO NOT use retired PRESIDE	*			BANKIN	ıc.
d 2	should be filed withind Mental Hygiene. marked other than matic event, the M		17. Father's Name (First, Middle, Last)		VIOL	TRESIDE	-	me (First, Middle			14
an		To Be	SAMUEL	DEMSEY			MOLLIE	•		Н١	/MAN
ary	12 should be f h and Mental I r is marked of raumatic eve	-	19a. Informant's Name/Relationship (7			g Address (Street					
Σ,	5 # 2 T		NORMA COHEN/DAUG			O SOUTH					
Baltimore, Maryland	# O		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	Place of Disposemetery, crem	sition (Name of natory or other place ERVICE C	ce)   Cr (	Date (0.000)	20c. Location	-	
ij			4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen			. Name and Addre	<u> </u>		TOWSON		
Ba	permit. Departr Importa any Inju		21. Signature of Funeral Savice Licen		_		•	SOL LEV	INSON &	BROS.	., INC.
			23a. Part 1. Enter the disease, or comp	lications that caused the de-						/1116	MD 21208 Approximate
1	Physician		shock, or heart failure. List only of Immediate Cause (Final	THEY WILDOW NO. 24 (7.40)	CAN	men					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Lue to (or as a consequ		LEK					WEEKS
	Examiner	L	Sequentially list conditions.	b							
	pe.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter or darrying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):						
	execut and al-tran	xan	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
260	cate be executed physician and the burial-transit	Sal		d							
68760,	tificat ig phy as the	ledi									
Вох	leath certificate be executed attending physician and for use as the burial-transit	cian/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	ξ <b>y</b>			ate of deliv	rery Day Year
0.	0 0		1 ☐ Yes 2 █ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	leath 5□	Other (specify) _	-		14	MOTHE	Day Teal
σ.	requires that the d been signed by the hould be detached	Physi	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to t	the cause of death?
Records,	S F e	d by	STROKE					1 🗆	Yes 2 No	3 ☐ Pro	bably 4 ☐ Unknown
000	law require las been sig 2 should b	olete						24a. Wa	s an 24b	. Were auto	opsy findings available
R	0 7 0	Completed		<del></del>				per	opsy formed? 2 No	prior to co death? 1 □ Yes	mpletion of cause of
of Vital	vysiclan: The iis certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only			
of ∨	ys is	၉	1 Tes 2 No	Hospital: 1   Inpatient 2			T I Ivai sing	Home 5 ☐ Res			ity) HOSPICE
	ling L. After fune	ioi:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	k?	28d. Describe	how injury occu	ırred	
isi	e at at	licat	2 Accident investigation 3 Suicide 6 Could not be		ome, farm, stre		Yes 2 □ No	28f. Location	(Street and Nun	nber or Rur	al Route Number,
Division	after after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	, , , , , , , , , , , , , , , , , , , ,			wn, State)		
n	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Medical C		ysician: To the best of my kno iner: On the basis of examina and manner stated.							
ť	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)
				11/1		26	4395		MAY	5,20	09
			30. Name and address of person who	completed cause of death (Item	1 23a) (Type, I	Print) CHAPLES	P 1900 1 - 1	mm 1 1 1 1 1 2			0.0-11
			JANIEUE DOBER-1 31. Date filed (Month, Day, Year)	32. Registrar's Signa	US N	CHAPLES	> 51,8Ul	1244 6	WITIMER	t, MC	21204
	Sta Regist	ate rar	MAY 0 7 2	Oz. Hajiosta o olgita	1 1	arkel					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

14713

Amend 20b State of Maryland / Department of Health and Mental Hygiene 2 0 9 Certificate of Death

O<sub>1</sub>×1

State Registrar 32 Registrar's Signatur

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

31. Date filed (Month)

J. Sark

111 Penn Street, Baltimore, MD 21201

30位

			For State Registrar	State o	f Marylan	•	rtment <i>tificate</i>		ealth and N Death	1ental Hy	gien Reg. No	0000	11.715
			Decedent's Name (First, Middle, in the control of the control	Last)						2. Date of De		av Year	3. Time of Death
	Physici /Medic		Johanna R. Do	rman						May 3,	2009	ear P	9:50A M
	Examin		4a. Facility Name (If not institution, g	give street and nu	mber)		4b. City, To	own, or	Location of Death		40	c. County of Death	
4			Stella Maris				Timo					Balto	
	Funeral		Social Security Number 6	. Sex 1 □ M 2 🛛 F	7. Age (In yrs.	-	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth a <i>y, Year</i>	9. Birthp	
	Director		212-30-9160	T IVI ZULI	75	Yrs.				Octobe	r 22	2,1983 M	aryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	/aryll	5	7/1	۹.		37 1-1-	1						1 ☐Yes 2 No
	the N	rect	Md . Ba	lto.		NOLL	inghan 10f. Zip C				10g. C	itizen of What Cour	ntry?
	with	٥	9122 Kilbride R	and			212	236				USA	
	ns 2	<b>Funeral Director</b>	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. V			spanic Origin? (Sp	ecify Yes or No	0-	14. Race - Americ	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Modical Examination relified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Gi Year or D	2 <b>∑</b> No ive		fYes,specif 1⊡Yes 2 <b>"</b> J		Specify:	Rican, etc.)		Black, White, Specify: Wh	etc. ite
215-0036	72 hor	Completed by	15. Decedent's (Specify only highest)	Education grade completed)		(Give	dent's Usual kind of work	done d	uring most of work	ing	16b. I	Kind of Business/In	dustry
121	vithin	ם	Elementary/Secondary (0-12)	College (	1-4or 5+)		DO NOT use	· · · · · ·	1			77	
nd 21	iled v Hygie ther i		12 17. Father's Name (First, Middle, La	(2)		HO	memake	er 	18. Mother's Nam	e. (First, Middle	. Maide	Home n Surname)	
Maryland	ntal l ed of	Be								Pistor			
ryla	d Me d Me nark	은	Joseph Crivell  19a. Informant's Name/Relationship			10b Mailie	a Address (	Street				or Town, State, Zij	2 Code)
<u>≅</u>	d2sl than 7isi		Mary A. Miller		DTR.	l .	Kilbı				-	Md. 21236	
	1 and Heal Heal em 2		20a. Method of Disposition			Place of Dispo				Date		_ocation - City or To	
Ĕ	Pages nent of nt: If it ry or c		t√ Burial 2 ☐ Cremation 3		State	emetery, cřen arkwoo		er place	9) 5-6-	2009	Pa	rkville,	Md.
alti	mit. partin porta / inju		21. Signature of Funeral Service Lie	censee	11	22	2. Name and	Addres	s of Facility S	chimune	k F	uneral Ho	me
Ba	permi Depar Impor any ir		Ma	M			970	)5 B	elair Rd	. Notti	ingh	am, Md.2	1236
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that only one cause on e	caused the deat	h. Do not ent	er the mode	of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		AL DISE	ASE							Onset and Death
	/Medical		resulting in death)		(or as a conseq								
	Examiner		Sequentially list conditions,	b									
	p ±	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	Due to	(or as a conseq	uence of):							
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C	(or as a conseq	uance of:							
68760,	icate be executed physician and the burial-transit	見		Due to	(or as a conseq	derice oi).							
87		dical		d									-
_	Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, ou	itcome of pregna	ancy						23d. Date of deliv	very
Вох	eath atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	ıìdeath 3 □	☐ Ectopic pre☐ Other <i>(sp</i> e		·			Month	Day Year
Ö	at the de by the tached	ysi	1 □Yes 2 🗶 No 9 □ Unknown	9 ☐ Unki			(-,						
σ.	that ned b deta		Part II. Other significant condition	s contributing to d	leath but not res	ulting in the u	nderlying ca	use give	en in Part I.	23e. Did	tobacco	use contribute to t	the cause of death?
ds	uires n sigr Id be	d by								1 🗆	Yes	2XNo 3□ Pro	bably 4 ☐ Unknow
8	w requires that s been signed to should be deta	ete								24a. Was	s an	24b. Were auto	opsy findings availab
al Record	<b>hysician:</b> The law his certificate has b I director, page 2 sl	Completed								_ perf	opsy orm <u>ed</u> ?	death?	ompletion of cause of
Vital	in: T ifficat or, pa		25. Was case referred to medical						26. Place of Dear	1 ☐ Yes		lo 1 □Yes	2 LJNo
	rsicia s cert lirect	o Be	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital:	Inpatient 2	LEB/Outnatier	nt 3 🗆 DO4	Othe				6 X Other (Spec	ify) HOSPICE
of	<b>ding Phy</b> h. After thii funeral c	<del> </del>	27. Manner of Death	28a. Date	of Injury	28b. Time of		c. Injury Work		28d. Describe			,,, HODI IOI
<u>0</u>	nding th.:: Aft	ţ	1 Natural 5 Pending 2 Accident investiga		nth, Day, Year)	Injury	М		.r Yes 2 ∐ No				
Division	for Attending after death. Director; After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad Zoe. Flace	e of Injury - At he	! ome, farm, str fv)	eet, factory,	office		28f. Location City or To	(Street a	and Number or Run	al Route Number,
Ö	at or s afte at Dir	le le	4 G Hornicide	Dunio	ang, etc. (opeon	9)				Only of 10	,,, o.u		
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical (	(Check only 2 Medical Ex	caminer: On the I	basis of examina							(s) and manner as nd place, and due	
	To the within 2 To the comple	Med	29b. Signature and title of pertifier	CLICTOR	er stated.		29c.	License	e number		29d. D	ate signed (Month)	, Day, Year)
	<b>5</b> <u>w</u> iti		1 A A AL AL A	1 dall	1		1	TILL	2707		5	4/7/19	
			30 Name of The 1000	XXIVI	on of death /i.e.	m 22 c\ /25	Print\	)/7/	1116			1100	
_	3 V		30. Name and address of person w					ъ	mTMONT!		1000		
	Sta	to.	JACKIE JONES,  31. Date filed (Month, Day, Year)	KNP 23	00 DULAI Registrar's Sana	NEY VAI	LLEY R	D	TIMONIUN	1, MD 2	1093	<u> </u>	
	Registi		<b>MAY 0 7 200</b>	Gener	Registrar's Sona	Har							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** may 41 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Battmore NA Hospita Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Social Security Number Funeral Months Davs Hours Min. 1 □ M 2**X**□ F 87 219-28-6593 VA 08 - 26 - 21Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be nutified at 1 X Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 USA Smallwood Street 1539 N. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 is marked other than "natural", or ite 1 ☐Yes 2 X No African 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2√∑No Specify. 3 Widowed 4 □ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6th Grade College (1-4or 5+) Domestic Homemaker 7 is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tuck Laura ဥ Alexander Rayland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 6 19a. Informant's Name/Relationship (Type. Print) Walker-Daughter 1539 N. Smallwood Street Baltimore, MD Virginia other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If II any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery 05-11-09 Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses Gilmor Street Baltimore, MD 2121 638 N 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Flatrolyte disease or condition resulting in death) /Medical Due to (or as a cons quence of): Examiner Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month Day,

Scrows Hospital

2000 W. Baltimore St. Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19 per fb 26 per verb 8891 5-7-709 vt State of Waryland Department of Health and Mental Hygiene 16b per FH g891 5/27/09 TT Certificate of Death For State Registrar Amend 16b per 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Eloise English 29 2009 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3814 Cedardale Road Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days 1 ☐ M 2 🕱 F 212-30-4918 86 27 Director 03 SC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Posicial Examiner must be notified at **Funeral Director** 1X Yes 2 □ No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 4010 Fernhill Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed by 3√ Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Spring<del>dale</del> State Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide 8th grade Hospital Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental H fitem 27 Is marked ott r other traumatic even Pages 1 and 2 should be Clemon Dow Rosa Lee Grant 19b. Mailing Address (Street and Number or Rural Route Number, Parkville 19a. Informant's Name/Relationship (Type. Print) City or Town, State, Zip Code) Kenneth English-Son Parkvy: 1423 Taylor Ave, Md 21234 e, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Removal from State Woodlawn Donation 5 Other (Specify) 5/5/2009 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 21 S nature of Funeral Service Licensee 23a. Pa t1. Enter the disease, or complications that —used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or help failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MALIGNANT NEOPLASM /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to or as a consequence of the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, pe Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) assisted Hospital: 1 ☐ Yes 2 ☒ No Other: 4 Nursing Home SA residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To living 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only MCRNP 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R125808 afr, from 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNEL. VII (ANDEVA, SEND 31. Date filed (Month, Day, Year) 32. Begistrar's Signature Smith Ave, Ste nos BALTO., ND 21209 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

			For State	State	of Mary	-	artment of F rtificate of		nd Mental F		000	11710	
			Registrar  1. Decedent's Name (First, Middle,	Last)			tineate of	Death	2. Date of		1119	3. Time of Death	
	Physicia /Medic		Charles E		st, Sr				Month May	5 2009	Year	8:15 A M	
	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town, o	Location of	Death		y of Death		
			24015 Meadows I		1 - 4 - 4	4 46 4 6	Ridge If Under 1 Year		4 Hrs. 8. Date of		rolin	1e place (State or Foreign	
	Funeral Director		5. Social Security Number 214-26-4925	6. Sex 1 🛣 M 2 🗆 F		yrs. last birthday) 19 Yrs.	Months Days	Hours	Min. (Month, March	Day, Year) 15 1930	Cou	place (State or Foreign ntry) Cy Land	
			Usual Residence of Decedent										
	irylan show 1 at	_	10a. State 10b. County		100	c. City, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	ne Ma 8a-f s	Director		oline			1	Ridgel	У	10g. Citizen of	What Co.		
	a or 2		10e. Street and Number 24015 Meadows	Dr.			10f. Zip Code	1660		_	USA	mey:	
	ns 23	Funeral	11. Marital Status	12. Was De	cedent Ever	in U.S. 13.			in? (Specify Yes or Puerto Rican, etc.)		ce - Ameri	can Indian,	
30	be filed within 72 hours after death with the Maryland ntal Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed f ed 1 [X]Yes If Yes, 0 Year or	2 □ No Rive	orea	1 ☐ Yes 2 ☒ No	an, Mexican, Specify:	, Puerto Hican, etc.)		ack, White, <i>ify:</i> Wh		
9500-612	2 hour		15. Decedent	s Education		16a. Dece	dent's Usual Occup	ation	and commission as	16b. Kind of E	3usiness/Ir	ndustry	
נוצ	within 72 iene. r than "nat the Medica	Completed	(Specify only highes Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	kind of work done DO NOT use retire	during most	or working				
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/iand	I be fill half He ed out	Be	17. Father's Name (First, Middle, I	_ast)	Erne	s†		Mary		die, Maiden Surna	me) Kno:	37	
Ž	should be nd Menta marked matic ev	٩	19a. Informant's Name/Relationsh	ip (Type, Print)			ng Address (Street		y r or Rural Route Nu	mber, City or Towi			
Mar	nd 2 salth ar 27 is r trau		M. Patricia Err				5 Meadows Dr. Ridgely Md.						
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition  1 Burial 2 Cremation	3 □Removal from	n State	Ob. Place of Disponentery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location	- City or T	own, State	
Ĕ			4 ☐ Donation 5 ☐ Other (Sp	pecify)			ematory I		5/9/09	Baltime			
ga	permit Depar Impor any in		21. Signature of Funeral Service	ice)n/sele	)~	1			/Stalling Rd. Pasad				
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	Physician		Immediate Cause (Final disease or condition	a V	My	cardi	1 1 5	are c	1 /			One Hour	
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9	certific ding p	0	IF FEMALE:	23c. If yes, c	outcome of o	regnancy				004 5	ate of deli-		
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200	endin sath. or: Aft he fur	atio	1∠Natural 5 ☐ Pending 2 ☐ Accident investig	ation			M 1	Yes 2□N					
DIVISION	i or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Pla bui	ce of injury - Iding, etc. (S	At home, farm, si Specify)	reet, factory, office		28f. Location City of	on (Street and Nur. Town, State)	nber or Ru	ral Route Number,	
)	To the Hospital or Attending Physis within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dire	Medical C		Examiner: On the		amination and/or i			d place, and due to th occurred at the t				
	To the within 2 To the complet	Me	29b. Signature and title of certifier		-//	1	29c. Licens	se number		29d. Date sign	ned (Month	n, Day, Year)	
			A A	>	4	X MI	D	474	192	Ma.	y Ce,	2009	
			30. Name and address of person								,		
		to	Jeffrey T. Den: 31. Date filed (Month, Day, Year)		555 Registrar's		Drive;	aston	, MD 2160	)1			
	Sta Registr		WAY A		M	-	backer						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0200 ORO **Physician** UMAS 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Linthicum Tate Hospice House Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Hours Months Days **Funeral** 1 M 2 F Maryland 03/09/1929 80 215 24 5424 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.
It if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be autilized at 10b. County 10a. State 1 ☐ Yes 2X No Anne Arundel Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21225 515 Holy Cross Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Specify: 1 ☐ Yes 2X No Specify. Baltimore, Maryland 21215-0036 White ģ Year or Dates: WW II 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) Fireman 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Ford Anna Murry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 515 Holy Cross Road Dorothea Ford / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Indenative County) permit. Pages 1 al Department of Hes Important: If item any injury or othe once. 20a. Method of Disposition Annville, Penna. 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 05/07/2009 4 □ Donation 5 □ Other (Specify) National Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatur - Fuzeral Service Lice Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between aset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death IF FEMALE: Year 23b. Was decedent pregnant Month 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the a d be detached fo P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Unknown Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performe ent Urinavty T page 2 s 1 ☐ Yes 2 2 No certificate 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Sp Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Consider the date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner. 29a. Certifier Medical (Check only one) 29b. Signature and title of Pertifie

5<sup>4</sup> V

31. Date filed (Month, Day, Year)

Name and address of p

32. Registrar's Signature

MAY 07 2009

There & fall

Registrar

Registrar
DHMH 17 Rev 1/2001

30. Name a

Day, Year)

2150 Pennsylvania Avenue, NW Washington, D.C. 20037

d address of person who completed cause of death (Item 23a) (Type, Print)

WELL

, Mo

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2009 May 3, 3:10 РМ Edward В. Furr, Jr. /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 25 5. Social Security Number Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Min 60 577-62-0927 1948 Washington, D.C. Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 ☐ Yes 2 X No North Potomac Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20878 13800 Hidden Glen Lane Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir. Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than any injury or other traumatic event, Ite Ms College (1-4or 5+) Elementary/Secondary (0-12) Auto Parts Store Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Brooks Edward B. Furr, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13800 Hidden Glen Lane, North Potomac, Maryland 20878 Kathy A. Furr / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 6, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 2009 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as eardiac or respiratory arrest, shock, or heart failure. List only one cause on eact line. Immediate Cause (Final **Physician** disease or condition resulting in death) 4000 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, cal Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O.1 After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 and address of person who completed cause of death (item 23a) (Type, Print) 9901 Medica William 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 9:10 p M **Physician** Greenberg Freda Κ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Chevy Chase Apt. 815 8100 Connecticut Avenue Date of Birth (Month, Day, Year) 10/3/1910 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1 ■ M 2 KF PA 98 201-12-5296 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 Yes 2 No Chevy Chase Montgomery MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 815 20815 Apt. 8100 Connecticut Avenue by Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: White Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kapnick Eva Kuntz ပ Hvman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chevy Chase, MD 20815 Department of Health an Important: If item 27 Is any Injury or other trau 3904 Woodbine St. Hillary Burchuk / Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 5/6/2009 Ardent Crematory 22. Name and Address of Facility Maryland Cremation Services 21. Signature of Funeral Service Licenses Baltimore, MD 21203 P.O. Box 1413 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 26. Place of Death (Check only one, 25. Was case referred to medical examiner? Be 2 ER/Outpatient 3 DOA 1 ☐ Inpatient

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, this completely filled in by the funeral After within 24 hours after death.

To the Funeral Director:

death with the Maryland

filed within 72 hours after

. Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 Is marked oft Jury or other traumatic even

Baltimore, Maryland 21215-0036

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

<u>11119 Rockville Pike</u> 31. Date filed (Month, Day, Year)

Rockville, MD 20852 #401 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital

Petek Donmez, MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Year 2009 May 4, 1:15 P M Robert John Griffing, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F April 23, 1943 66 082-34-0369 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14804 Dunleith Street 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 1965–1968 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🗷 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Computers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert John Griffing, Sr. Elizabeth Byrnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan S. Griffing/Wife 14804 Dunleith Street, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home/Rockville, Inc. M01548 300 W. Montgomery Avenue, Rockville, Maryland 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC smmi disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 14 No 24a. Was an autopsy performed? Yes 2 ZiNo 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nation 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined

the death certificate be executed physician and s the burial-trans Box 68760, o detach ۵. Division of Vital Records, has

After Hospital or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

hours after death

within 72

Hygiene.

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Department of harmonic of harmonic life and injury or of once.

**Physician** 

Examiner

/Medical

Maryland 21215-0036

Baltimore,

Pages

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Examiner

Physician/Medical

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Be

Medical Certification: To

3 Suicide

29a. Certifier

4 Homicide

(Check only

Qx1 State

29b. Signature and

29c. License number D 35635

DR

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Dav. Year) 2009

20832

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18111 Prince Philip JOSEPH KAPLAN, MD

31. Date filed (Month, Day, 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ena Horne	State of Maryland / Department of Health and Mental Hygiene 2009 1472								
		1- For State Certificate of Death		R		2 1416			
Physicia		Decedent's Name (First, Middle,Last)		2. Date of Dea Month	th	3. Time of Death			
ledical Exami	ner	Lena Horne		April 29, 2	Day Year 2009	0045 hrs			
2)			vn, or Location of Do	eath	4c. County of Death	1			
		1004 East North Avenue Baltimor			N/A				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir	thplace (State or			
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		Usual Residence of Decedent							
wan		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
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AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shematic event, the Medical Examiner must be notified at nace	일	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (	Street and Number	or Rural Route Num	nber, City or Town, State	, Zip Code)			
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altimore, mit. Pages 1 ar partment of Hee portant: If ite		1 XBurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Mt. Zion Ceme	terv 5	/4/09	Lansdowne	∍,Md			
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Balti permit. Departm Imports injury o		5240 Re	isterst	own Rd	Baltimore	neral Nome ,Md 21215			
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Sox 6876( leath certificate e attending phy- for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pre	gnancy		oay Year			
Box (e death or the attenced for use	Sici	4 Pregnant at time of death 5 Other (Specify)							
C. B. the de sched f	죍	Part II. Other significant conditions contributing to death but not resulting in the underlying car	use given in Bert I	23a Did to	bacco use contribute to	the cause of death?			
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Sior Attenc r death ector: by the	崽	2 Accident Investigation	Yes 2 No						
Division tal or Attendi rs after death al Director: /	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, off	ice building, etc.	28f. Location (S or Town, S	street and Number or Ru tate)	ral Route Number, City			
E 8 5		4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time		, <b>,</b>					
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To the within To the comple	Medical	and manner stated.	cense number	une time, date à					
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			.C.IVI.E.		April 29, 2009				
		30. Name and ad ress of person who completed cause of death (Item 23a)	ro MD 24224						
		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimo							
Sta Regist		31. Date filed (Month, Day, Year)  NAY 0 7 2009  32. Registrar's Signature							
	-	PIA U LUUJ AANTO PO. PY							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 1, **Physician** 2009 2:10 A M Cooper Thurman Holt. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Min. txTxM 2∏ F 08 - 03 - 1924415-14-0541 84 Tennessee **Director** Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or Items 23a or 28a-f shovevent, the Wedical Exeminer at 1 ☐ Yes 2 TNo Director MD Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4222 Rose Petal Court 21043 United States death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or Ite 1 XYes 2 No If Yes, Give Year or Dates: 1943 1 ☐ Never Married 2 A Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify þ Specify: 1944 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Director of VFW Veteran Service Org. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mae Rachel Poole George Washington Holt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Holt - wife 4222 Rose Petal Court, Ellicott City, MD 21043 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. Elkridge, Maryland 05-05-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M01275 21. Signature of Funeral Service Licensee MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCVEATIC YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transi Exam and Due to (or as a consequence of): P.O. Box 68760, the attending physician death certificate be Physician/Medical the as IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month signed by the at I be detached fo 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 1 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

201

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Charles ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Samue1 Harrison, Jr. May 03 2009 6:59 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 926 South Wieker Road Severn Anne Arundel 9. Birthplace (State or Foreign Country) South Carolina If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 6/7/1939 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Hours Days Min. 1**X** M 2 □ F 69 **Director** 219-26-7637 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 926 South Wieker Road 21144 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 □ Yes 2 □ No Specify \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Carpenter U.S. GOvernment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel HArrison , Sr. Lillie Mae Davis ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalee Harrison / Wife 926 South Wieker Road, Severn, Maryland, 21144 If item 27 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any Injury or Meadowridge Memorial | 5/9/2009 | Elkridge. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last aminer Due to (or as a consequence of): 23d, Date of delivery Month Vear 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No ath (Check only one)

/Medical Examiner law requires that the death certificate be executed and burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria as signed by the a d be detached f page 2 should or Attending Physician: The

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than

Pages 1

	l	Due to (or as a consequence of			
IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	nonths?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic 5 ☐ Other (		
Part II. Other signifi	cant conditions	contributing to death but not resulting in	n the underlying	cause given in Part I.	_
25. Was case referre	ed to medical			26. Place of I	_ Dea
1  Yes 2 <b>2</b> ✓	<b>K</b> No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 🗆 [	OOA Other: 4 ☐ Nursin	g F
			траниен		
27. Manner of Death 1. Natural 2 Accident	5 ☐ Pending investigatio	28a. Date of Injury (Month, Day, Year)	Time of njury	28c. Injury at Work? 1 □ Yes 2 □ No	
27. Manner of Death	5 Pending	28a. Date of Injury (Month, Day, Year) 28b. 1	Time of njury	28c. Injury at Work? 1 □ Yes 2 □ No	

Home 5 Residence 6 □ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

of certifier

29c. License number 1038912 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, GLEN BURNIE, Nd. 21061 - DR. Salvacio RAMIREZ 7845 OAKWOOD 31. Date filed (Month, Day, Year)

State Registrar

after death

within 2 To the I

Hospital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 450M ANCE Matthew Earl Hutson 30, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Anne Arundel Glen Burnie Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 1 x M 2 □ F 218-14-7048 84 Director May Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7728 Central Avenue 21122 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Completed by Specify: 3 ₩ Widowed 4 Divorced White 16b. Kind of Business/Industry traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) 8 Diesel Mechanic Diesel Engines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Landon Hutson Calie Arnold ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley J. Davies 7728 Central Avenue, Pasadena, MD 21122 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date May Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, Maryland 21. Signature of Funeral Service (ic-nsee/ 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complication that cous shock, or heart failure. List only one car so on each Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of The law requires that the death certificate be executed 735 Mugict CUNONIZ burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performe 1 🗆 Yes 2 🗆 No 1 ☐ Yes 2 | NO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After the funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACI NONE WASHINGTON arna MINICAL 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner

**Funeral** Director

filed within 72 hours after death with the Maryland Hygiene. r than "netural", or Items 23a or 28a-f show the Medical Examiner must be notified at other Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked o Depertment of H Important: If Ite any Injury or of once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

The law requires that the daath certificate be executed attanding physicien and for use as the burial-transit signed b should I certificete After this certifiin funeral director, J Director: , within 24 hours a To the Funerel [

Division of Vital Records, P.O. Box 68760,

Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 2009 May 1, 8:50 P M Eleen Fraley Hill 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Collingswood Nursing Home Rockville If Under 1 Year If Under 24 Hrs. Month, Day, Hours Min. June 13, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1926 1 □ M 2 🗓 F Washington, D.C. 82 Yrs. 220-12-6127 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 X Yes 2 □ No Maryland Montgomery Rockville Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20850 United States 502 Beall Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Statistician Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Francis Fraley Helen Ester Markley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Beall Avenue, Rockville, Maryland 20850 Mildred Myers / Sister May 7, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20050-2005 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Peripheral Vascular Disease Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Dementia that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4M Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the basis of examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ( May 4, 2009 D30132 30. Name and works of person who completed cause of death (Item 23a) (Type, Print) 14812 Physicians Lane, #161, Rockville, Maryland 20850 Rita Ghosh, M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date (filed (Month) Day, Year)

B. park

32. Registrar's Signature

	-	** *		State of Maryland / Department of Health and N	-	•	
				1 - State Registrar Certificate of Death		eg. No. 200	9 14729
		Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	0 <sup>Day</sup> , 20°0	3. Time of Death 9:42 AM
4	23	/Medio	al	Charles E. Jones  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Мау	4c. County of D	
	1	EXAIIII	lei	602 N. Monroe Street 2nd. Fl. Baltimore		N A	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   2 1 7 - 2 4 - 8 3 5 4   1	8. Date of Birth (Month, Day, 11-20-	Year) 9.	Birthplace (State or Foreign Country)
	H,	Director		217-24-8354 78 Yrs. Usual Residence of Decedent	11-20-	-30	MD
		with the Maryland sa or 28a-f show	'n	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 □ No
		the M	Director	MD NA Baltimore  10e. Street and Number 10f. Zip Code	1	0g. Citizen of What	
ß		th with	al Di	602 N. Monroe Street 21217		USA	-
a)		tems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc. African
Jon	036	urs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【XNO If Yes, Give 1 ☐ Yes 2 【X No Specify: Year or Dates:		Specify:	African American
· Lil	5-0036	72 hou	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of works)	ina	16b. Kind of Busine	
	2121	within ene. than "	dmo	(Specify only highest grade completed)  Elementary/Secondary (0-12)  9 th Grade  NA  (Give kind of work done during most of work life. DO NOT use retired)  Laborer		Rothloho	m Steel Co
. 1 e	ld 2	il Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name			m Steel Co
Char	ylar	Menta Menta arked atic ev	To B	Roland Jones Alice		Randa1	1
บ	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with hjury or other traumatic event, the Medical Exactive must by routh of anone.	Y Y	19a. Informant's Name/Relationship (Type. Print)  Tonya Watkins  19b. Mailing Address (Street and Number or Run  1007 Lakemont Road		-	
·· U	e,	of Hea		20a. Method of Disposition 20b. Place of Disposition (Name of complete properties) and the place of Disposition (Name of complete properties).		20c. Location - City	
De	Baltimore,	Page		4 Donation 5 Other (Specify) King Mem. Pk. Cem. 05	-09-09	Baltim	ore, MD
	Ball	permit Depart Import any In		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Wy 1  638 N. Gilmor St			
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
4		Physician		Immediate Cause (Final disease or condition resulting in death)  a. Coronary Artray			Onset and Death
		/Medical Examiner		Due to (or as a consequence of):			
		T =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):			
		ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
	68760,	eath certificate be executed attending physician and for use as the burial-transit	cal E	Due to (or as a consequence of):			
	687	rtificate ng phy as the	Medic	0.		1	
	Вох	ath ce ttendir or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of Month	delivery Day Year
	P.O.	at the de by the a tached f	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			24,
	S, D	ires that signed t	5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death?
	ŏrd	w require been si should b	eted	Apportunition, 19 min punter			Probably 4 ☐ Únknown
	Bec	sician: The law certificate has t irector, page 2 s	Completed		24a. Was a autops perforr	ry prior deatl	autopsy findings available to completion of cause of 1?
	<u>ta</u>	lan: T	BeCc	25. Was case referred to medical 26. Place of Death	1 ☐ Yes		′es 2⊟No
	<u>&gt;</u>	hysic this ce al direc	ဥ	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 TReside	ence 6 Other (5	Specify)
	ono	ding F h. After funera	tion:	1 ⊟Natural 5 □ Pending (Month, Day, Year) Injury Work?	28d. Describe ho	ow injury occurred	
	Division of Vital Records,	or Attending Physician: The law requires that the death certificate be executed with death. Director: After this certificate has been signed by the attending physician and birector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	2 Activities 6 Could not be	28f. Location (Si City or Town	treet and Number of	Rural Route Number,
		To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	ŕ		r on ototod
2 Ril		he Hos n 24 h ne Fun pletely	Medical	(Check only one)    Check only one   Check one   Check only one   Check one   Check one   Check one   Check	red at the time, d	ate and place, and	due to the cause(s)
		Voithi Com	Ž	29b. Signature and title of certifier  29c. License number  25 7 5 4 7	2	9d. Date signed (M	
			-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		> - 3	<b>3</b> 9
				P. SANDHU, MD 1940 W. BALTIMURE ST	BALT	IMURE !	NA 21283
		Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature		•	
		riogistii		MAY 07 200 Denus G. Jours			

dical Exami	Cause (Disease or injury that initiated events resulting in death) Last  C. Advanced Lonento  Due to (or as a consequence of):  d.										
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗆 Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year					
ed by Pr	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	g cause given in Part I.	4	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown					
Complet					24a. Was an autopsy performed						
Φ	25. Was case referred to medical	26. Place of Death (Check only one)									
O B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	I ER/Outpatient 3 □	DOA Other: Nursing	Home 5 ☐ Residence	e 6 ☐ Other (Specify)					
Certification: To	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred					
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fact	ctory, office 28f. Location (Street and Nun City or Town, State)		t and Number or Rural Route Number, tate)					
Medical (		ysician: To the best of my kniner: On the basis of examin and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)					
Σ	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month, Day, Year)					

D 30641

4:00 A.M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

2009

1 ☐ Yes 2XXNo

Howard

New York

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 24 hours after death To the Funeral Director: filled in by the

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramesh Sabapalti 201-109 Back RIVEY neck Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear **Physician** 04 1320AM Cia 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death ity Name (If not institution, give street and number) Examiner Masylant altimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 9, Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔽 F Months Days Hours 215-59-0850 62 1946 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a·f show traumatic event, if a Medical Exyminer must be notified at 11⊈TYes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21204 7001 N. Charles Street USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 ∐Yes 2 V No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) beautician cosmotology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Barlow Genevieve Freeland ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun Beverly Mehan/sister 906 Saxon Hill Drive Cockeysville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 K Other (Specify) 21. Sign turo of Euneral Project lices Nonal d S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Wade 21201 Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final schemic Disease **Physician** Heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknow signed by 1 I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 4 🗹 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 certificate 1 □Yes e Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the l within 2 To the l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar John

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

3. Registrar's Signature

Greene Gt, Baltimore MD 2120/

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 6:50 P. M Rose M. Jericek 2009 Mav /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Morningside House of Friendship Hanover 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🛭 F Maryland 94 215 01 9791 1914 Director May 7, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2K☐ No notified Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit, Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be a 21804 U.S.A. 229 Canal Park Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Crossing Guard Baltimore City 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Jericek Anna Lenc ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 229 Canal Park Drive #201 Salisbury, Maryland 21804 M. Rosann Anderson / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 05/05/2009 Holy Cross Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Puneral Service L 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEAR **Physician** DEMEN disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and Due to (or as a consequence of) Records, P.O. Box 68760, physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 113141617101 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops perform Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manufer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director; After ti After 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the I within 24 and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 30. Name and address of person who completed of death (Item 23a) (Type, Print) CRAIN TOWERS ICHARD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day PM 2009 KONOPKO HERMAN 5. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BAL TIMORE JOHNS HOPKINS BATVIEL MEDICALCENTER If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/26/1927 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1⊠M 2□F 215-22-6132 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 🔀 No Baltimore Baltimore MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 U.S.A. 7208 Birch Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married 1 ∐Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bethlehem Steel Mechanic 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Mina Abramoski Joseph Konopko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21222 Birch Avenue, Baltimore, Cecelia Konopko/ Wife 7208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

**Physician** /Medical **Examiner** law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

attending physician and for use as the burial-tran

certificate has been signed by the rector, page 2 should be detached

**Physician** 

/Medical

Examiner

Director

Funeral

9

Completed

Be

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**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinat neural be notified at once.

	4 ☑ Donation 5 ☐ Other (Specify)	silloval ilolli State	Anatomy Gif	ts Reg	istry	5/7/20	009   H	lanover, N	Maryland
	21. Signature of Funeral Service Lic in e	е	22.	Name and	Address of Fa	acility Anat	omy Gif	ts Regist	try
	1505		75	22 Cc	nnelle	y Dr.,	Ste.P,	Hanover,	MD 21076
	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ATORT		of dying, such		respiratory arres	st,	Approximate Interval Between Onset and Death
ıminer	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events		MONIA						1 WEEK
Completed by Physician/Medical Examiner	resulting in death) Last								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of d Month	lelivery Day Year
	Part II. Other significant conditions con	tributing to death but no	ot resulting in the und	derlying ca	use given in P	art I.			to the cause of death?  Probably 4 Unknown
Complete							24a. Was an autopsy perform 1 □ Yes 2	ed? I death'	autopsy findings available o completion of cause of ? es 2 □ No
Be (	25. Was case referred to medical			26. Place of Death (Check only one)					
	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient	2 ER/Outpatient	3 🗆 DO	Other: 4 [	Nursing Hom	e 5 🗌 Resider	nce 6 Other (Sp	pecify)
ation: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Ye	28b. Time of		c. Injury at Work? 1 □ Yes	28		v injury occurred	
Medical Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
dical	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Examin	sician: To the best of mer: On the basis of ex and manner stated	amination and/or inv	occurred a estigation,	at the time, da in my opinion	te and place, a , death occurre	nd due to the ca d at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
Me	29b. Signature and title of certifier			29c. License number 29d. Date signed			d. Date signed (Mo	nth, Day, Year)	
	Emily K De		RES-000 MAY 6				2009		

Registrar DHMH 17 Rev 1/2001

State

parke

EASTERN AVENUE BALTIMORE, MD

4940

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DESCHL

EMILY

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar BOI HOSPITAL DRIVE, GLEH BURNIE, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIANGRECO

GUILLERMO DOSE

31. Date filed (Month, Day, Year)

amend #8 Per ANA BD G89115/11/09k Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Grason I. Krebs 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson <u>Baltimore</u> 8. Date of Birth (Month, Day, Ye July 28, If Under 1 Year | If Under 24 Hrs. yJ.928 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☑ M 2 □ F 80 1929 217-24-4841 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the involced Examinant rust by modified at MD Fallston 1 ☐ Yes 2 ▼ No Harford Director 10e. Street and Number 25 Mountain Road 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: white ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Krebs Marie Schwarz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona Krebs/spouse 25 Mountain Road Fallston, MD 21047 permit. Pages 1 and Department of Healt Important: If item 2! any injury or other? Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signature of Suneral Socio S Wade Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final omplications of **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes plnods peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPIU 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 □Yes 2 □No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the 29b. Signatur 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles Sr towson ms M HARON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 07 2009 Registrar

14736

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** USEP H 042009 2300 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F Months Days Hours Min. New Jersev Director 138-09-4782 May19,1914 94 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the modical Examinar must be redified at Director 1 TyYes 2 □ No Essex Nutley New Jersey 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 145 Bloomfield Avenue 07110 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Mechanic <u>Pharmacutica</u>] 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental Peter Lordy 2 Louisa Fleurs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 27 Lorraine Lewis/Daughter Department of Health Important; If item 27 any injury or other the once. 12216 Major Driv<u>e, Germantown, Maryland20876</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glendale Cemetery: 5-8-09 Bloomfield, New Jersey 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee marguelle 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) neumonia. Examiner Sequentially list conditions, Physician/Medical Examiner ir any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No the detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 2 No 1 ☐ Yes 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \to \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 29d. Date şigned (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) elular 0110 Mo 31. Date filed (Month, Day, Year, Registrar's Signature 32. State 7 MAY 0 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05-02-2009 **Physician** 6:25 A M Denise Jane Lempka /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 1929 Cypress Drive Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11-26-1939 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F 69 Mass. Director 037-26-2841 Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examinar mass has a second 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1929 Cypress Drive 21015 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harrison Seveney Mildred Norton ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald A. Lempka (Husband) 1929 Cypress Drive Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens 05-08-2009 Aberdeen, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W.MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final ADENOCARCINOMA OF UNKNOWN PRIMAR **Physician** YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (of as a consequence of) Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Completed Be Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and istey filled in by the funeral director, page 2 should be detached for use as the burial-transit nets. Division of Vital Records, P.O. Box 68760.

						1 □ Yes 2 €	No 3 Probably 4 Unknown
						24a, Was an autopsy performed? 1 □Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □Yes 2 □No
25. Was case referred to medical					26. Place of De	ath (Check onl one)	
examiner? 1 ☐ Yes 2 ☐ №6	Hospita	<sup>al:</sup> 1 ☐ Inpatient 2 ☐	] ER/Outpatient	3 🗆 [	DOA Other: 4 Nursing H	Home 5 Residence 6	Other (Specify)
7. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	g jation	a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could 6 4 ☐ Homicide determ		e. Place of Injury - At h building, etc. <i>(Speci</i>	ome, farm, stree	t, facto	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,	
	Examiner: 0				ed at the time, date and plac on, in my opinion, death occ		and manner as stated. place, and due to the cause(s)

29c. License number

D0062100

To the Hospital within 24 hours a To the Funeral L

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE MARYLAND

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registrar

1650

29b. Signature and title of certifier

ORLEAMS

STREET

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** Mary Angeline Micucci 1230PM MOW 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 800 River Road Sykesville Howard 8. Date of Birth 12/02/1914 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex **Funeral** 1 □ M 2 🗗 F Months Days Hours Min Pennsylvania 159-12-9529 94 Director Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Wedien Everifier must be redified at 1∏Yes 2¥ No Director Sykesville MD Howard the 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21784 U.S.A. 800 River Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖔 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Specify: White Completed by 3 ☐ Widowed 4 🛭 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd 2 should be filed within lith and Mental Hygiene.
27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) unknown Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant: If Item 27 ls i 644 River Road, Sykesville, MD 21784 James Hess/Grandson Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o once. 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Ardent Cremation Services : 05/07/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signatur of Funeral Sovice Licensee 7522 Connelley Drive, SteN, Hanover, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atheroscleration Immediate Cause (Final **Physician** ardio vascular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence of: Examiner Physiclan; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 I I Inknown 9 ☐ Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 4 Unknown 2 No 3 Probably cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1 ☐ Yes 2 No : After this certific funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2DKNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 2 ☐ Accident 5 Pending 124 hours after death.

Reference of the Funeral Director: Af 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Nieme Sufe 203 31. Date filed (Month, Day, Year) legistrar's Signature State MAY 07 Registrar

		•	for State Registrar		iai yiai ic	•	rtificate of	Death	Re	eg. No. 🤈	009	14730
	Physicia /Medic		Decedent's Name (First, Middle  William		Stewa	rt	McC	orkle	2. Date of Deat Month 05	O1	2009	3. 7 ime of Death
	Examin		4a. Facility Name (If not institution		r)			or Location of Death	1		ty of Death timor	
A. C.	Funeral		Gilchrist Hos 5. Social Security Number	6. Sex 7. A	ige (In yrs. la	ıst birthday)	If Under 1 Year		8. Date of Birth			ace (State or Foreign
	Director		213-32-6460 Usual Residence of Decedent	1 <b>∏</b> M 2□ F	69	Yrs.	Months Days	Hours Min.	09 27	Year) 39	Count	MD MD
	yland how		10a. State 10b. County		10c. City,	Town or Lo	cation				10	d. Inside City Limits
	e Ma Ba-f s	cto	MD NA	1		Balt	imore					Yes 2□No
	vith th	Funeral Director	10e. Street and Number				10f. Zip Code	1015	1	0g. Citizen of	What Count	•
	eath v	eral	4306 Granada  11. Marital Status	Ave	t Ever in II S	13		1215	necify Ves or No.		ace - America	
2-003p	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ant, the Recited Evan incornation notified at	ē	1 ☐ Never Married 2 ☐ Marri 3 🙀 Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 If Yes Give	? ]No		lf Yes, specify Cub 1 □ Yes 2 ☑ No	Hispanic Origin? (Spean, Mexican, Puerto	o Rican, etc.)		ack, White, e	
2	72 ho 'natur	Completed	15. Deceden	it's Education st grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of I	Business/Ind	ustry
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70	e filed within al Hygiene. other than * vent, the Me	ပ္ပ	12th grade 17. Father's Name (First, Middle,	Last) na			401102		ne (First, Middle, M			
<u> </u>	fental Red c	To Be	William McCor					Katie :	Skinner			
nary	ges 1 and 2 should be filed it of Health and Mental Hyg If item 27 is marked othe or other traumatic event,		19a. Informant's Name/Relations	thip (Type, Print)	h +	I	-	t and Number or Ru				
, 2	and 2 ealth n 27 i	ı S	Cornetta McCo	rkle-In-L				le Ave,				
Saltimore	Pages 1 alment of Heanant: If item		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (S	3 ☐ Removal from State pecify)			esition (Name of matory or other pla morial	rce) Park 5/		20c. Location Wood $f 1$	•	
Dall	permit. Page Department. Important: II any injury o		21. Signature of Funeral Service	Licensed K-	ke	M	2. Name and Addr arch F/ 300 Wah		. Balti	more,	Md 2	21215
			23a. Pa 1. Enter the disease, or shick, or heart lure. List	complications that can-	the death.	. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-a. AV	OXIC	5 6	ram	INIW	24		(	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque	ence of):	ial i	Marci	ran		(	days
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, S	rtificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last	c. Due to (or a	s a conseque	ence of):		y ac	July		1	
00/00	ate be	ledical		d								
Ď X	certific ding p		IF FEMALE:	23c. If yes, outcom	e of pregnar	ncv				224 5	nata at dalina	
	To the Hospital or Attending Physician: The law requires that the death cen within 24 hours after death. After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3[	☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су			ate of delive Month	ry Day Year
'n	s that gned b		Part II. Other significant condition	ons contributing to death	but not resul	ting in the u	nderlying cause gi	ven in Part I.	23e. Did tol	bacco use co	ntribute to th	e cause of death?
cords,	equire	ted 1	eville	<i>A</i> +					1 🗆 Ye	es 2 No	3 X Prob	ably 4 Unknown
ב	The law r te has br age 2 sh	Completed by							24a. Was a autops perforr		o. Were autor prior to cor death? 1 ☐ Yes	osy findings available inpletion of cause of
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5	ding P h. After funera		27. Manner of Death  1 Natural 5 ☐ Pendin  2 ☐ Accident investig	28a. Date of In (Month, D		28b. Time o Injury	Wo	uryat urk? ∐Yes 2 □ No	28d. Describe ho	ow injury occu	ırred	
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5	ital or ins after al Direction is led in its	Certification:	4 Homicide determ	building, e	etc. (Specify,	)			City or Town	n, State)		
	he Hosp in 24 hou he Funei ipletely fil	Medical	29a. Certifier (Check only one)	ng Physician: To the bes Examiner: On the basis and manners	of examinati	vledge, deat ion and/or in	h occurred at the avestigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and late and place	manner as si e, and due to	tated. the cause(s)
)	To T To 1	Σ	29b. Signature and title of certifie	ulm			29c Licen	se number 5830	3 1	9d. Date sign	ned (Month, I	Day, Year) I-DOG
			30. Name and address of person	who completed cause of	death (Item	23a) (Type	Print)6701	N-Ch	arlei S	FDA	NSW	V MÓ
	Stat Registra		31. Date filed (Month, Day, Year)	7 2009 32. PAIS	trar's Signati	d. A	harles					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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amend items 7.8 per fb 8891 5-28-09 yr
State of Maryland Department of Health and Mental Hygiene

_		_	1 - State Registrar Co	ertificate of Death	Reg. No. 2009 4740
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> <b>Judith Mosley</b>		North Day 2009 Year 3. Time of Death 8:00 P M
	/Medio		4a. Facility Name (If not institution, give street and number) Augsburg Lutheran Home	4b. City, Town, or Location of Death  Lochearn	4c. County of Death  Baltimore
\$ .	Funeral Director		5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  1 □ M 2 □ XF  66  64	// If Under 1 Year   If Under 24 Hrs.   8. D Months Days Hours Min.   10	oaten Birth 94.2 Molecular State of Foreign Country Colorado
	yland now at		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or		10d. Inside City Limits
	the Mar 28a-f sl	ector	MD Baltimore Loc	thearn  10f. Zip Code	1 ☐ Yes 2 💆 No  10g. Citizen of What Country?
	th with 1	al Dir	6811 Campfield Road	21207	United States
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed by Funeral Director	1 X Never Married 2 ☐ Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates: unk	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical 1 ☐ Yes 2 No Specify:	Specify: White
15-(	in 72 h n "natu Aedical	plete	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry
212	ed with ygiene. <b>rer tha</b> i	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Clerk	Retail
land	ld be fil ental H ked ott ic even	To Be	17. Father's Name ( <i>First, Middle, Last</i> )  James Mosley	unk	st, Middle, Maiden Surname) Young
, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	Nancy Puls, Friend 8766	iling Address (Street and Number or Rural Ro Ruppert Court, Ellic	cott City, MD 21043
nore			T Buriai 2 Dicremation 3 Hemoval from State	position (Name of Pate Place)  Crematory 05/05/0	20c. Location - City or Town, State  Glen Burnie, MD
Baltimore,	permit. Popertme Departme Important any injury once.		4 □ Donation 5 □ Other (Specify) Atlantic  21. Signature of Fundal Service Licensee T. Harman	22. Name and Address of Facility Skall	da Funeral Home
8	9 4 E 2 9		23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	2829 Hudson Street, I	•
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	lateral sclero	Offset and Death
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68760,	tificate k g physic as the b	ledical	d		
. Box	death cer e attendir d for use	Physician/N		B∐Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
Δ.	requires that the een signed by th hould be detache	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Tyes 28No 3 Probably 4 Unknown
l Rec	The la ate has page 2	Completed by			24a. Was an autopsy performed?  1□ Yes SANo 24b. Were autopsy findings available prior to completion of cause of death?  1□ Yes 2□ No
Vital	Physician: The this certificate har al director, page	Be	25. Was case referred to medical examiner?  1   Yes   252 No	26. Place of Death (Cf	neck only one) 5 ☐ Residence 6 ☐ Other (Specify)
n or	ing Phys offer this uneral dii	on: To	27. Manner of Death  1- Natural 5 Pending (Month, Day Year) Injur	of 28c. Injury at 28d. Work?	Describe how injury occurred
Division or	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	M   1   Yes 2   No   street, factory, office   28f.	Location (Street and Number or Rural Route Number, City or Town, State)
	Hospita 24 hours Funeral rtely fillec	Medical C	29a. Certifier (Check only one)  Check only one)  And manner stated.		
	To the within 2	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
				737573	May 4, 2009
_	81		30. Name and address of person who completed crase of drath (Item 23a) (Type Super Mark)	D 737573 e, Print) St. Revtesta	MD SIIS6
· Ly	Sta Regist		31. Date filed (Month, Day; Year) 32. Registrar's Signature	Land	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6:35 PM Carol Lee Moore 2 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country) If Under 1 Year
Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🛛 F Hours 217-36-2764 69 05-23-1939 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show ns 23a or 28a-f shov 1 ☐ Yes 2 ☑ No **Funeral Director** PA York Airville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4237 Delta Rd item 27 is marked other than "natural", or items; other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter C. Taylor Elizabeth Wheatley ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary E. Moore (Husband) 4237 Delta Rd Airville, MD 17302 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Bel Air Mem. Gardens 05-06-2009 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Prention disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached it 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: certificate 2 **⊠**No 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 1 Lapatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Aatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 Homicide To the Hospital on within 24 hours aft To the Funeral Di 29a, Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

MOORE,

MOMPSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 07 2009

resapeake

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	tate of Maryland		rtment of H			iene <sub>eg. No</sub> 2 ()	19	1474	2
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h		3. Time of Death	1
	Physicia /Medic		Roland Murphy					Month April	Day	Year 2009	1:20 P	М
	Examin		4a. Facility Name (If not institution, give street	_		4b. City, Town, or	Location of Dea		4c. Count	y of Death		
			Sinal Hospital OF	BALTIMORE	- 1 h 2 d - 1 - 1	If Under 1 Year	OPC If Under 24 Hr	s. 8. Date of Birth		0 Pirtholo	ce (State or Fore	oian
	Funeral Director		5. Social Security Number 6. Sex 1 N M	7. Age (In yrs. Ia 2□ F 91	Yrs.	Months Days	Hours Mir		1917	Country	) Totale of Tu	irk
			Usual Residence of Decedent									
	ırylan show	_	10a. State 10b. County	10c. City,	Town or Loc					10d	I. Inside City Lim 1 Y Yes 2 □	
	ne Ma 28a-f	ecto	MD		Balti	more			0g. Citizen of	What Country	21	
	with t	Ξ	10e. Street and Number 2500W. Belvedere Aver	nue #87			1215	'	og. Onizen or	USA		
	be fled within 72 hours after death with the Maryland tatal Hygiene. And there is now do other than "natural", or items 23a or 28a-f show event, If a Macalcal Evaminer must be notified at	Funeral Director	11 Marital Status 12.1	Was Decedent Ever in U.S	13. V			(Specify Yes or No- erto Rican, etc.)		ce - Americar		
٥	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? U1 I □Yes 2 □ No fYes, Give		Yes, specify Cuba  ☐ Yes 2 No	Specify:	erto Hican, etc.)		ick, White, etc		
0000-01	ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:				unk	Specify: white un 16b. Kind of Business/Industry ur			tie .
5	"mat	lete	15. Decedent's Education (Specify only highest grade co	n mpleted)	(Give I	ent's Usual Occupa kind of work done of OO NOT use retired	lurina most of w		160. King of E	susiness/indu	stry	in the second
7 :	withing the man	Completed	Elementary/Secondary (0-12) unk unk	College (1-4or 5+)		0 110 / 200 / 0 00,						
ב ב	al Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)	•	-	unk	18. Mother's Na	ame (First, Middle, M	Aaiden Surna	me)	ur	ık
<u>a</u>	2 should be filed and Mental Hygi is marked other aumatic event, I	To										
Ξ	. <b></b>		19a. Informant's Name/Relationship (Type. Sinai Hospital	Print)	19b. Mailing 2401	g Address (Street a W. Belve	and Number or A dere Av	Rural Route Number enue Balt	; City or Town imore,	n, State, Zip C MD 2:	1215	
י	Fages 1 avuent of Hee ant: If item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☑ Other (Specify)		ace of Dispos metery, crem	sition (Name of atory or other place	e)	Date	20c. Location	- City or Tow	n, State	
ם .	permit. Pages Department of Important: If it any Injury or once.		21. Signature Onall Ce Licensee	Director		Are and Address	•	rd 655 W. 201	Baltin	nore St	reet	
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complete the complete	ons that caused the death.					est,	Í	Approximate nterval Between	
P	hysician		Immediate Cause (Final disease or condition	- 1 0 0	eath.					C	Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequent			12					
	-xammer	<u>.</u>	Sequentially list conditions, b	Due to (or as a consequ	inte o	property s	- Hon	C .			I have.	
	Ired I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury								20,000	^
ב <u>ֿ</u>	an and rial-tra	Exa	that initiated events ' c resulting in death) Last	Due to (or as a consequent	ence of):	orace of					V 90000	
0 / 0	requires that the death certificate be executed teen signed by the attending physician and nould be detached for use as the burial-transit	dical	d									
Ď:	ding p	/Me	IF FEMALE: 23c	If yes, outcome of pregnar	ncv				224 D	ate of deliver		
ָ מַ	atten for us	Completed by Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	/				y Day Year	
)	oy the	hysi		9 Unknown		- (, ,,						
, i	s mar gned t e deta	y P	Part II. Other significant conditions contrib	uting to death but not resul	lting in the un	derlying cause give	en in Part I.	23e. Did to			cause of death	
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<u>.</u> د	aw nas be	ple						24a. Was a autops perfori		prior to com	sy findings availa pletion of cause	able of
<u>,</u>	cate h	Con						perfori 1 □ Yes	med? 2 DANo	death? 1 ☐ Yes 2	No	
ָ : בַּם	sician certif rector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hosp	ital: 🖟		Othe		eath (Check only on				
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5 :	ath. r: Afte e fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury		<br Yes 2 □ No					
	or Atter degarder deg	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	Be. Place of Injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S. City or Town	treet and Nun n, State)	nber or Rural	Route Number,	
	To the hospital or Attending Priystolan: The law requires that the death certification 24 hours after death. After this certificate has been signed by the attending prophetely filled in by the funeral director, page 2 should be detached for use as	Medical Ce	29a. Certifier 1 ☐ Certifying Physici (Check only one)	an: To the best of my know On the basis of examinat and manner stated.	vledge, death ion and/or inv	n occurred at the tir vestigation, in my o	ne, date and pla pinion, death oc	ace, and due to the occurred at the time, o	cause(s) and late and place	manner as sta e, and due to t	ated. the cause(s)	
;	within To the	Me	29b. Signature and title of certifier			29c. License	e number	2	29d. Date sigr	ned (Month, D	ay, Year)	
ď			> Spr. 1	NBBS		RES	000		4801 18	2009		
			30. Name and address of person who comp		23a) (Type, I			11 40 )	1 ^	0 1:	100 -0 MA	212
			31. Date filed (Month, Day, Year)	32 Bonietrar's Grand	TOF B	ALTIMORE.	2701 L	wood between	iere Hi	e, balt	עווא שוטונן	445
	Sta Registr		MAY 07 2009	32. Registrar's signat	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** May 4, 2009  $P^{M}$ Lillian S. Mangione 11:41 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 26, 1929 **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 082-22-2769 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examings must be notified at **Funeral Director** 1 XYes 2 No Hillsborough Florida Tampa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 33611 3823 North Oak Avenue #K-41 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify White Completed by Specify 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications 10 Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Raphael (Ralph) Severino Josephine Foti ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7526 Coxton Court, Unit A, Alexandria, VA 22306 JoAnn Mangione/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 7, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Inc. Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final enic V C lion **Physician** a disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner ordio myopath 2 C hemi equentially list expanding, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nclume 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 10 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 i Inpatient 2 i ER/Outpatient 3 i DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria P.O. Box 68760 Division of Vital Records, after death Director:

24 hours a To the within 2.

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Sobelle

6 Could not be determined

3 Suicide

29a Certifier

4 Homicide

29b. Signature and title of certifier



HIERTIG

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0054068

Shady Grove

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

VERA NICHOLSON

			Please	Type or Print in Black in				
			For State		artment of Health and Me <i>rtificate of Death</i>		0000 1171	1.
			Registrar			Reg. No.	3. Time of Deat	4
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	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	40	c. County of Death	
- m - 1				tospital	BALTIMORE  If Under 1 Year   If Under 24 Hrs.   8	. Date of Birth	9 Birthplace (State or For	niar
	Funeral Director		216-28-88021	ex 7. Age (In yrs. last birthday) ☐ M 2 X F	Months Days Hours Min.	(Month, Day, Year	930 New Jerse	2)
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Lin	nits
	Maryl f sho	ŗo	MI	4 Balt	200000		1 X1Yes 2□	No
	the 28a	rec	10e. Street and Number	Dan	10f. Zip Code	10g. C	itizen of What Country?	_
	3a o		3510 W/101	lington St	21229		USA	
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Special	y Yes or No-	14. Race - American Indian,	
9	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1  ☐ Yes 2  ☐ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ☑ No Specify:	carr, etc.)	Black, White, etc.	
93	ral",	d by	3 ₩ Widowed 4 □ Divorced	Year or Dates:	Times zygliło opeciny.		Specify: Black	
2	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show umatic event, the "radical Event" had, instituted at	Completed	15. Decedent's Ed (Specify only highest gra-	de completed)   (Give	dent's Usual Occupation kind of work done during most of working	16b. I	Kind of Business/Industry	
12	/ithin ne. <b>han</b> '	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	150	leral Reserve Bo	n
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and	l be fintal l ed ol	Be	17. Fattlet's Name (1 1131, Middle, Last)		Mag	11/11	160,000	
Ž	hould d Me mark matic	မ	19a. Informant's Name/Relationship (7	Time Print) di Ulah tan 19h Maili	ng Address (Street and Number or Rufal F	Oute Number City	or Town State Zin Code)	_
Maryland 21215-0036	d 2 s Ith ar 27 is trau		Mc Vera	011/15/1	- N Grantley	+ D/	1th M/ 2/25	, 0
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midical Event inc. ust be notified an any injury or other traumatic event, the Midical Event inc. ust be notified an apprise.		20a. Method of Disposition	20b. Place of Dispo	osition (Name of Date	e 20c. l	_ocation - City or Town, State	~
ē			1 ☐ Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	matory or other place)	2009 R	often md	
Baltimore,	nit. Fartme ortan injur		21. Signature of Funeral Service Licen	CHEETING	2. Name and Address of Faity	1111	CITOLINA	_
ä	permi Depa Impo any ii		Daronh	& Kun J	oseph L. Russ tu	neral H	one PH 21716	
			23a. Par 1 Enter the disease, or comp	olications that caused the death. Do not en	ter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between	
	Physician	8 /9	shook, or heart ailure. List only of immediate Cause (Final		ock		Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):			1 Day	
	Examiner		Conventielly list conditions	Acute ren	al failure		1 Day	
	D ==	Examiner	Sequentially list conditions, if any leaving to immediate cause. Enter Underlying Cause (Disease or injury	une to (or as a nonsequence or):			12.	
	ecute and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	c. <u>Codquiopi</u>	d thy		1 Day	
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87	death certificate attending physi	dic		, d				
×	certif iding se as	Me	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery	
ă	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year	
o.	uires that the de signed by the a d be detached f	Physician/Medic	9 Unknown	9 🗆 Unknown				_
ώ. π	s that gned l e det	by P	Part II. Other significant conditions of	ontributing to death but not resulting in the u		23e. Did tobacco	use contribute to the cause of death	?
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<u> </u>	The ate h page	Completed				performed? 1 ☐ Yes 2 🗷 N	death?	-
/ita	cian; ertific ector,	Be (	25. Was case referred to medical examiner?		26. Place of Death (	Check only one)		
<u></u>	hyslo this c		1 ☐ Yes 2 ☐ YNo	Hospital: 1 X Inpatient 2 ☐ ER/Outpatie			6 ☐ Other (Specify)	
Ĕ	ing F	io i	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Work?	d. Describe how inj	ury occurred	
<u>s</u>	ttenc death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be			f Location (Street	and Number or Rural Route Number,	_
Division of Vital Records, P.O. Box 68	after Direct Jin by	Certification: To	4 Homicide determined	building, etc. (Specify)	lock, ladioly, office	City or Town, Sta	te)	
	To the Hospital or Attending Physician. The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the			ysician: To the best of my knowledge, dea				
	ne Ho n 24 l ne Fu	Medical	(Check only 2 Medical Exan	niner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s)	
	To the company	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)	
			Kodetla N	herris M. D.	P21799.	m	ay 5 2009.	
i.	11		^	completed cause of death (Item 23a) (Type				
	1		900 Caton 31 Date filed (Month Day Year)	Ave BAITMON  32. Registrar's Signature	e, MD 21829			_
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 7 2009	levers A. barke	/			

1-	For State Registrar

Physicia /Media Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, Regist

	1 - State Registrar			Cert	tificate of L	Death			Reg.	No.			
-	1. Decedent's Name (First, Middl	le, Last)						2. Date of Month		Day V	001	3. Time of D	eath
in	Anita Marie O	Anita Marie O'Brien May 5, 2009						eai	3:25P	M			
al er	4a. Facility Name (If not institution		4b. City, Town, or Location of Death					4c. County of	Death				
	Rockville Nur 5. Social Security Number	thday)	Rockville If Under 1 Year   If Under 24 Hrs.   8, Date of Birt					Montgomery  9. Birthplace (State or Foreign					
	033-10-8928	6. Sex 7. 1 □ M 2XXF	Age (In yrs. last bir 89	Yrs.	Months Days	Hours	Min.	8. Date of (Month, Marc			Coun	achuset	
	Usual Residence of Decedent		140 G2 T								14	Od Jacida Cik.	Limite
tor	10a. State 10b. County  Maryland Montgo		Rockvi		ation						,	0d. Inside City 1 X Yes 2	
rec	10e. Street and Number	J2 J	1		10f. Zip Code				10g.	Citizen of Wha	at Coun	ntry?	
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11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Black, White, etc.								etc.					
by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:	1	□Yes 2 <b>X</b> No	Specify:				Specify:	Whi	te	
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mo	12			ibra	ry Assis	tant			P	ublic S	Scho	ools	
Se C	17. Father's Name (First, Middle,	, Last)				18. Mothe	er's Name	(First, Mid	dle, Maid	den Surname)			
To E	Roger Lang					Ka	ther	ine L	owne	У			
	19a. Informant's Name/Relations	ship (Type. Print)	19b	. Mailing	g Address (Street a	and Numbe	er or Rura	al Route Nu	mber, Ci	ty or Town, St	ate, Zip	Code)	
	Rogean Sikorsk	i/Daughter	4	4 St	onepath	Court	, Ro	ckvi1	1e,	Marylaı	nd	20854	
	20a. Method of Disposition		20h Place o	f Dienne	sition (Name of natory or other plac		May			. Location - Ci		own, State	
	1 X Buriai 2 □ Cremation 4 □ Donation 5 □ Other (5		Gate	of H	eaven	.e)	мау 2009		Cd	lver S	owir	or MD	
	21. Signature of Funeral Service		Ce	emet	ery Name and Addres	ss of Facili							ome/
	1 . 18		MOORO	Ro	Name and Addres	Inc.	300	West	Mon	tgomer	y Av	enue	· · /
	23a Part 1 Enter the disease of	r complications that ca			ckville,							Approximate	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Interval Between Onset and De	een eath	
	disease or condition resulting in death)  Chronic Congestive Heart Failure								_	Years			
	Due to (or as a consequence of):									Years			
_	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):										lears		
ine	cause. Enter Underlying Cause (Disease or injury										V		
хап	that initiated events resulting in death) Last		rent Urii ras a consequence		Tract I	ntect	lons				-	Years	
Medical Examiner		1	as a consequence	0.,.									
dic		d									-		
/Me	IF FEMALE:	23c If was outer	ome pf pregnancy							004 5-4-			
ian/	23b. Was decedent pregnant in the past 12 months?	1□Live bir	th 2 Fetal death		Ectopic pregnancy	/				23d. Date of Month			ear
/sic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□Unknov	nt at time of death vn	٥⊔	Other (specify)				_				
Medical Certification: To Be Completed by Physician/	Part II. Other significant condit.	ions contributing to dea	th hut not resulting i	n the un	dedving cause dive	en in Part I	I.	23е. Г	id tohac	co use contrib	ute to #	he cause of de	ath?
by	Recurrent		ar but not resulting t	ii aic dii	deriying cade give	on are are			□Yes	**		pably 4∏Ur	
ted		rneumonia										Sabiy 4 de	
ple								) a	Vas an utopsy	pri	or to co	opsy findings av impletion of cau	vailable use of
ПO								1□ Ye	erformed s 2 💢		ath? ]Yes	2□ No	
3e (	25. Was case referred to medica	al				26. Place	e of Death	h (Check or	nly one)				
examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other								e 6 □Other	(Specia	fy)			
<u>:</u>	27. Manner of Death 1 X Natural 5 ☐ Pendi	28a. Date of		Time of Injury	28c. Injur Wor	y at k?		28d. Descr	be how i	injury occurred	i		
atic	2 Accident invest	tigation				Yes 2□	]No						
iffic	3 Suicide 6 Could 4 Homicide deterr	minod   Zoe. Flace o	f injury - At home, fa g, etc. (Specify)	arm, stre	eet, factory, office			28f. Location	n (Stree Town, S	t and Number	or Rura	al Route Numb	er,
Sen										ŕ			
Sal		ing Physician: To the b											
edic	one)	and manne		110/01 1114	restigation, in my c		atii occui	red at the ti	me, date	and place, an	id dde t	o trie cadae(a)	
Ž	29b. Signature and title of certific	er			29c. Licens	e number			29d.	Date signed (	Month,	Day, Year)	
	Fraul	d Which	had M k		D001	9785			Ma	y 6, 2	009		
	30. Name and address of persor	n who completed cause	of death (Item 23a)	(Type, F									
	Frauke Westpha	1. M.D. 1	201 Seven	Loc	ks Road,	Rock	kvill	.e, Ma	ryla	and 20	854		
te	31. Date filed (Month, Day, Year		gistrar's Signature										
ar	MAY 0.72	nno &	~ 1. 4	Box 1	21								
	TALV (	UUJ WHAL	~ p. g	MAA									

Sta

**Physician** /Medical Examiner

ending physician and use as the burial-tran

attending p for use as

certificate has been signed by the rector, page 2 should be detached

spital or Attending Physician: Theory after death.
Ineral Director: After this certificate if filled in by the funeral director, pa

To the Hospital within 24 hours a To the Funeral I Hospital

Completed by

Be

Certification: To

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

**Physician** 

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

t of Health a

item 27

Department of Important: If it any injury or conce.

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underwing Cause (Disease or injury that initiated events Physician/Medical Examiner resulting in death) Last IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1⊠Yes 2□No

1 X Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

27. Manner of Death 5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) 28b Time of Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

16443

28d. Describe how injury occurred

26. Place of Death (Check only one)

autopsy performed'

1 ☐ Yes 2 X No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

May 3, 2009

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

David Patterson, M.D. 2440 M Street, NW, Suite 817, Washington, D.C. 20034

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

abiaii Faiiilei		1- For State	State of	viaryianu /		tificate of		na menta	ai Hygierie	Reg. N	. 21	JU!	14/4
⊷Physicia Medical Examir	n/	Registrar  1. Decedent's Name (First	, Middle,Last)						2. Date of Month	Death Day			3. Time of Death 0555 hrs
Culcar Examilia		Fabian 4a. Facility Name (if not in	stitution, give stre	Pau eet and number)	1	41	Palm o. City, Town,		May 3,		4c. County o	of Death	
		University Hospit					Baltimore		-				····
Funeral Director		5. Social Security Number 218-65-46	6. Sex		(in yrs. la 24	st birthday) Yrs.	If Under 1 Ye Months Da	ear If Under ays Hours	24Hrs. 8. Date of Min. 07	of Birth (M	м/dd/үүүү 84		Jamaica Jamaica
,	-	Usual Residence of Dece	dent			+			<u> </u>				10d. Inside City Limits
nd ihow any ce.	- 1	10a. State 10b. C	<sub>ounty</sub> Ba <b>lti</b> mo		10c. City,	Randa		n n				ŀ	1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number					10f, Zip Code	-		10g. (	Citizen of Wh	at Count	ry?
ith the 23a or notifie		3917 Nemo		Was Bassinst	Francia (1)	140 1440		21133	n? ( Specify Yes o	or No.		S . A .	an Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "matural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 X Never Married 2	F	Was Decedent I Armed Forces? Yes 2	X No	If Ye	s, specify Cub	an, Mexican,	Puerto Rican, etc.	)	White	e, etc.	
s after tral", o	2	3 Widowed 4	or I	ates:	nlotod\ T	16a Decedent	Λ_	No specify:	ind of work done	116	Specify: b. Kind of Bu		ack
hin 72 hours after e. thau "natural", edical Examiner	eted	15. Decedent's Education  Elementary/Secondary		College (1-4 or 5		during mo	st of working li	fe. DO NOT u					
036 vithin 7 ene. er thau	Completed	12th grad		na		D:	isc Jo				Self		.oyed
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nativity or other traumatic event, the Medical Exa	Be Co	17. Father's Name (First, Earlin Pa							s Name (First, Mid			)	
212 ould be d Ment s mark		19a. Informant's Name/Re		Print )				eet and Numb	ber or Rural Route	Number	, City or Tow		
MD and 2 shows alth and sm 27 is raumati		Earlin Pa 20a. Method of Dispositio		ther	I ann E	3917 Place of Disposit			Randa		OWN,		
Baltimore, permit. Pages   ar Department of Hee Important: If ite		1 X Burial 2 Cre		Removal from Sta		rematory or oth	er place)	cemetery,				-	
ultimit. Pa artmen sortant	1	4 Donation 5 O 21. Signature F eral S	ther Specify: Service Licensee	1		Woodla	awn ame and Addr ch F/	ess of Facility	5/16/0	9   V	voodla	a w II ,	ма
Balt permit. Departu Import injury		Fint	WK.	//		1430	00 Wak	oash A	ve, Ba				21215
Physician /Medical		23a. Part I. Enter the dise failure. List only one	cause on each li	ne.			e mode of dyir	ng, such as ca	ardiac or respirator	ry arrest,	shock, or he	art	Approximate Interval Between Onset and Death
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	_	Sequentially list condition		to (or as a conse	augnes of	a.				_			
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nd nd transit		events resulting in death)		to (or as a conse	equence of	): 							
760, cate be executed physician and he burial - transit	Medical	UNPENDED	_ Al	MENDED									
8760 ifficate b ng physi		IF FEMALE: 23b. Was decedent pregna		3c. If yes, outcom	ne of pregr		al death	3 Ectopic	pregnancy		23d. Date of Month	,	ay Year
Box 687( e death certifica the attending pl	Physician/	past 12 months?	Unknown 6	Pregnant at	time of de	-45	er (Specify)			- 1			
that the de		Part II. Other significant	- '	Unknown	but not re	esulting in the u	nderlying caus	e given in Pa	rt I. 23e.	Did tobac	cco use contr	ribute to t	the cause of death?
i, P.O.	d by								1	Yes 2	2 No 3	Prob	ably 4 Unknown
ords, w requir as been s	Completed									Was an autopsy			topsy findings available ompletion of cause of
tal Recition: The la	Eog								1 🗸	performe Yes 2		✓ Ye	s 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to examiner?	Hosp	ital: 1 Inpatie	nt 2 🗸	ER/Outpatient		Other	(Check only one)  Nursing Home	5 Res	sidence 6	Other	
1 of Vi ding Physi  After this funeral dir	5 7	1 ✓ Yes 2 I	No	28a. Date of Inju	ırv	28b. Time of Ir		njury at Work	? 28d. Des	cribe how	injury occur		
Sion attendir death. ctor: A y the fu	atio	1 Natural 5 2 Accident	Pending Investigation	May 3, 2009		0511 hrs		Yes 2 🗸					
Division of Vital Records, spital of Attending Physician: The law require hours after death.  Ineral Director: After this certificate has been signified in by the funeral director, page 2 should be a spital of the funeral director.	Certification:	3 Suicide 6	Could not be determined	28e. Place of In (Specify) Loc			t, factory, offic	e building, etc	or To	wn, State			ral Route Number, City  Md.
<u>ie</u> 8 <u>ie</u> 1		4 ✓ Homicide  29a. Certifier 1 Certifier (Check only)	ying Physician:	To the best of my	y knowled	ge, death occur	red at the time	, date and pla	ace, and due to the	e cause(s	) and manne	r as state	ed.
To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title o	an	manner stated.	mination a	nd/or investigat		ense number	curred at the time,				nth, Day, Year)
			~ J.	wi?				C.M.E.			May 4, 20		
		30. Name and address of											
			ssistant Med		r 111 r's Signatu	Penn Stree		e, MD 212	:01				
St Regist	ate trar	31. Date filed (Month, De	07 2009	Gener	- Sugnatu	A. 100	Mes						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death an 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05-05-2009 **Physician** 0618 A M Ronald Paul Pillar 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9 Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ₹ M 2 □ F 213-36-4946 70 Director PA Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Harford Bel Air MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21015 2001 Ruffs Mill Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental Beulah A. Barr Paul A. Pillar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21015 Department of Health a Important: If item 27 Is any injury or other tra 2001 Ruffs Mill Rd Bel Air Jean J. Pillar (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05-11-2009 Baltimore,MD Bayview Crematory 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Schimunek Funeral Home Of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a cust equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical cate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part,II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No Division of Vital 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2**√**∑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

2009

07

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ess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 21 State of Maryland / Department of Health and Mental Hygienes Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2009 Hnn 30 A O /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner (+5479 Linth An ne un 0450 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Age (/ **53 Funeral** Months Hours 04/03/1956 Min. Days 1 M 2 X F 212-70-2969 MD Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ?7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, tradition Examination must be notified at Yes 2□No N/A **Baltimore** MD Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number with **USA** 21230 1616 Belt Street Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: ð 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) BWI Airport Waitress 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Romaine Morris Neil Andrew Ridgell, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4705 Charlestown St., Baltimore, MD 21225 of Health Wayne Morris - Stepfather item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/29/2009 Baltimore, MD Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. per DVR Donna Znamirowski 4001 Ritchie Highway, Baltimore, MD 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and it be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown this certificate has been s al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2/N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 ☐ Yes 2 ☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifie 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 10 32 egistrar's Signatur Day, Year)

State Registrar

MAY 0 7 2099

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death? Month **Physician** USEN /Medical Ball T 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. Medic ercu 5. Social Security Number If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 ▼ M 2 □ F 58 Director 9-9-1950 219-50-4916 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director 28a-f MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ö items 23a Funeral 211 Ε. Lafayette Avenue 21202 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 XNo 1 Never Married 2 Married Maryland 21215-0036 6 If Yes, Give Year or Dates à 1 ☐ Yes 2 X No Specify: Specify. Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Dep rtment of Health and M intal Hygiene. Important: if item 27 is marked other than 'any injury or other traumatic event, it is item. Once. Elementary/Secondary (0-12) College (1-4or 5+) 11th grade N/A Disabled Disabled 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Eugene Matthews Prilliam 2 Sr Lucilla Braboy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corine Jones-Sister 4376 Shamrock Avenue Balto, MD 21206 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 5-2-2009 Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 North Ε. Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of): Examiner tricio 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examine and Il-transit The law requires that the death certificate be executed physician a s the burial-t Due to (or es a consequençe of): 68760 Be Completed by Physician/Medical signed by the attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tyes 2 🗌 No 3 Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performed? 1 Yes 2 No certificate **Division of Vital** Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2√□ No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 □Yes 2 □ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 0 JUVI 31. Date filed (Month, Day, 82. Registrar's Sign State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 710 A 05-01-2009 Joan P. Quinn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford 2009 Tiffany Terrace Forest Hill 8. Date of Birth 03-13-1934 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 💢 F 75 Yrs. 212-30-9625 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ \*\*\* any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2009 Tiffany Terrace 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Forest Hill Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Kelly Albert V. Hogan ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 Tiffany Terrace Forest Hill, MD 21050 John J. Quinn (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Ignatius Cem. 05-04 -2009 Hickory, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) monto **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? nditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an

Director: /

IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 Mo 9 ☐ Unknown	
Part II. Other significant co	×
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24b. Were autopsy findings available prior to completion of cause of

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Be	25. Was case referred to medical		26. Place of Death (Check onl	y one)				
To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5 A	esidence 6 Other (Specify)				
Ë	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	e how injury occurred				
Certificatio	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ctory, office 28f. Location City or 7	(Street and Number or Rural Route Number, Fown, State)				
Medical (	29a. Certifier  (Check only one)  Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
ž	29b Signature and title of control		29c. License number	29d. Date signed (Month, Day, Year)				

(Check only one)  2 Medical Examiner: On the basis of examination and/or investigone)		
9b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
PHYSTICT MY	D0058475	MAY 12000

PHYSICIAV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROAD. BECAIR ATWOOD

State Registrar

31. Date filed (Month, Day, Year)

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within 24 hours a To the Funeral C

completely

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April 30, 2:40 AM **Physician** 2009 Mary Elizabeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Burnie Anne Arundel Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F Yrs. January 30, 1930 New York Director 79 091-24-2417 Usual Residence of Decedent 10d. Inside City Limits fshow 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f showevent, the Wordel Even Front out to south 1 ☐ Yes 2 X No Director Howard Savage Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **HSA** 20763 8928 River Island Drive Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 5-0036 1 ☐ Yes 2 No Specify Specify þ 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Apartment Manager Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Ethel Cummings Robert Mackey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 Lisa Fischer- Granddaughter 8455 Limerick Ave, Winnetka, CA 91306 permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State May 4, 2009 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery Laurel, Maryland 21. Signature of Fun ra Service Licensee 22. Name and Address of Facility Fleck Funeral Home, MO123 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical Due to (or as a consequence of): Examiner una Lancer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to lor as a consequence of Physician: The law requires that the death certificate be executed Exami the burial-trai Due to (or as a consequence of): Box 68760. physician Physician/Medical as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day been signed by the atte should be detached for Month 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? the funeral director Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be To the Hospital or Atter within 24 hours after de: To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifie 30. Name and address of person who combleted cause of death (Item 23a) Type, Print 0/ KOSP tal Drive, 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		**		artment of Health and		_	
		_ State		rtificate of Death		g. No. 2009	11,753
		Registrar  1. Decedent's Name (First, Middle, Last)		rimeate or Beatir	2. Date of Death	1	3. Time of Death
Physicia		ESTELLA RANDLE			Month APRIL 2	Day Year 26. 2009	11:16 A <sup>M</sup>
/Medica Examine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat		4c. County of Deat	
Examine		3731 LUMAR DRIVE		FT. WASHINGTON		PRINCE GI	EORGE'S
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday		8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
Director		204-42-3330   1□ M 2X F   57	Yrs.		JAN. 16,		
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
/laryla	ö		FT. WASH	TMCTON			1 X Yes 2 □ No
the houtif	Director	MD PRINCE GEORGE'S  10e. Street and Number	FI. WASH	10f. Zip Code	10	g. Citizen of What Co	untry?
3a og		3731 LUMAR DRIVE		20744	Į	JSA	
death	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer		14. Race - Ame Black, White	
after or ite		1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒☐	No	1 □Yes 2 ☑ No Specify:	to ( noun, oton)	Specify:	
be filed with 72 hours after death with the Maryland tall Hygiene.  Hal Hygiene was a core see show ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				1	BLACK
"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)		16b. Kind of Business/	industry
withii iene. than	mo	Elementary/Secondary (0-12) College (1-4or 5	i+)	RACT SPECIALIST		DC GOVERNI	1ENT
filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)	1 00111		ne (First, Middle, M		
Anta be Aenta rked tic ev	10 B	JOSEPH THOMPSON		EUGENI	A WAGSTAI	FF	
shou and h		19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street and Number or R	ural Route Number,	City or Town, State, 2	Zip Code)
and 2 salth n 27 l		MARIO LANZA RANDLE / HUSBA	ND 3731	LUMAR DRIVE FT.	WASHING		)744
les 1		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place)	Date	20c. Location - City or	Town, State
Pag Iment Iant: I		4 □ Donation 5 □ Other (Specify)		TAN CREMATORY 05-		ALEXANDR	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ucensee		2. Name and Address of Facility MA			
<u> </u>		V	E. SLOCUM	4308 SUITLAND RO		TLAND, MD	20746
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	I the death. Do not er ne.	iter the mode of dying, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		resulting in death)		MALFORMATION, CAR	DIAC		
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ifficate or, pa		25. Was case referred to medical		26 Place of De	1 □Yes 2 ath <i>(Check only on</i>	71	3 2 □No
ysicia s cer	To Be	examiner? Hospital:	ent 2 ER/Outpatie			ence 6 □Other (Spe	ecify)
g Phy ter thi	-	27. Manner of Death 28a. Date of Inju	ry 28b. Time			w injury occurred	
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ithin 2 ithin 2 o the	Med	29b. Signature and title of certifier	ated.	29c. License number	2	9d. Date signed (Mon	th, Day, Year)
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		30. Name and address of person who impleted cause of c	leath (Item 23a) (Type	Print)	/ /	Jones of	1
10		Solvator Schotter B	ed Hos	oital Drive	Charl	MARY	land
Stat		31. Date filed (Monta Day Year 7 2000 32. Sgiste	ar's Signature	ball	//		
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			1- State of Maryland / De State of Maryland / De Per dr., g893,0	partment of Health and I 7/29/09dhb ertificate of Death		9 14754
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Kim Delisa Roper		2. Date of Death  Month Day Y  April 25, 20	ear 30 M
)	Examin Funeral	er	4a. Facility Name (If not institution, give street and number)  **MURYANA General Superior Security Number 6. Sex 7. Age (In yrs. last birthdom)  220 86 4705 1	Months   Davs   Hours   Min.	4c. County of N/2  8. Date of Birth (Month, Day, Year) 9  06/21/1967	
	Director		Usual Residence of Decedent  10a. State		00/21/1907	10d. Inside City Limits
	ith the Mar or 28a-f st oe notified	Director	Maryland N/A Balti  10e. Street and Number  264 Ballou Court	10f. Zip Code 21231	10g. Citizen of What	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depardment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Moral Eximiner must be notified at once.	Funeral		3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		American Indian, White, etc.
21215-0036	n 72 hours a "natural", c	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. De	ecedent's Usual Occupation live kind of work done during most of work be DO NOT use retired)	16b. Kind of Busin	B1ack ness/Industry
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Maryland	12 should b h and Ment 7 is markec traumatic e	2		er, Jr. Jew ailing Address (Street and Number or Ro 7 Terra Firma Road		tate, Zip Code) Maryland 21225
Baltimore, I	Pages 1 and ent of Healt nt: If item 2: ry or other:		20a. Method of Disposition 1≦ Burial 2 ☐ Cremation 3 ☐ Removal from State	sposition (Name of crematory or other place)	Date 20c. Location - C	ity or Town, State e, Maryland
Balti	permit. P Departm Importal any injul	, i	21. Signature of Funeral Service Licensee	22. Name and Address of Facility GC 4001 Ritchie Highw	nce Funeral Serv ay Baltimore, M	aryland 21225
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8760,	ficate be executed  sphysician and  sthe burial-transit  the partial of the purial of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	Visionse and Eketh	olyte Tmbalance	
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<u>S</u>	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide building, etc. (Specify)  29a. Certifier (Check only Medical Examiner: On the basis of examination and/	death occurred at the time, date and place	City or Town, State)  ee, and due to the cause(s) and may	nner as stated. nd due to the cause(s)
	To the He within 24 To the Fu	Medical	29b. Signature and title of certifier	29c, License number	29d. Date signed	(Month, Day, Year)
	V		30. Name and address of person who completed cause of death (Item 23a) (The Rahman Language of the Samuel Completed Cause of death (Item 23a) (The Rahman Cause of the Cause o	phyland General Sales	al Hospital	
	Sta Regist		31. Date filed (Month, Day, Year)  32. Pegistrar's Signature	hard		

DHMH 17 Rev 1/2001

09-03468 Charles W. Shou	ırde	Please Type or Print in Black Indelible  State of Maryland / Department of				a grang grant (
Chanes VV. Shoc		1- For State Certificate C			200	
Physicia Medical Exami		1 Decedent's Name (First, Middle,Last) Charles William Shourds, Jr.		April 29, 20	Day Year 109	3. Time of Death 1525 hrs
Co		Facility Name (if not institution, give street and number)     Sas Harborside Drive, Apartment D	4b. City, Town, or Location of Death  Joppatowne	1	4c. County of Death Harford	
Funeral Director		5. Social Security Number , 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24Hrs Months   Days   Hours   Min		Cou	hplace (State or Foreign untry)
		406-72-7189   1 XM 2 F   60 Y Usual Residence of Decedent	rs.	April	26,194Þ K	entucky
ow any		10a. State 10b. County 10c. City, Town or Loc				10d. Inside City Limits  1 Yes 2 No
aryland 8a-f she at once	Director	Kentucky Ohio Beaver D	10f. Zip Code	10	g. Citizen of What Cour	71
h the M 23a or 2	1	1148 Williams Street	42320		U.S.A.	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
after de	by Fu	3 Widowed 4 X Divorced of Yes, Give Year or Dates:	Yes 2 X No specify:		Specify: Whi	
2 hours			ent's Usual Occupation (Give kind of most of working life. DO NOT use ret		16b. Kind of Business/I	ndustry
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215-( oe filed at Hyg ked oth	Be Co	17. Father's Name (First, Middle, Last)  Charles Williams Shourds, Sr.		e (First, Middle, M Kinchel		
imore, MD 2121! Pages 1 and 2 should be fil ment of Health and Mental Is tant: If item 27 is marked or other traumatic event,	Tol	19a. Informant's Name/Relationship (Type, Print ) 19b. Mail	ing Address (Street and Number or	Rural Route Numb	ber, City or Town, State	
e, MD 1 and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of Disp	SWilliams Stree	Date	20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		1 Burial 2 X Cremation 3 Removal from State Owens or Owens of Gardens	oro Memorial 5-	-8-09	Owensboro	,Kentucky
Baltimo permit. Page Department of Important:		2 1 1 1 1 0 11	. Name and Address of Facility ${ t Mass} { t 009 Harford} { t Roa}$	rzullo	Funeral	Chapel, P.
Physician		23a. Part I. Enter the disease, or condications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):				Death
1 19.	L	Sequentially list conditions, b				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ecuted and transit		events resulting in death) Last  Due to (or as a consequence of):  d.				
), be exec sician ar urrial - t	dical	UNPENDED AMENDED				
OX 68760, eath certificate be exentending physician for use as the burial.	cian/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn	ancy	23d. Date of deliver	y Day Year
Box 6 e death ce the attend ed for use	ysici		Other (Specify)			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the thin street or After this certificate has been signed by the attending physician and inpletely filled in by the funeral director, page 2 should be detached for use as the burial - trans	by Physi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to	
ds, Frequires	eted			24a. Was a	an   24b. Were au	utopsy findings available
Recol The law icate has l	Completed			autops perform 1 ✓ Yes 2	med? death?	completion of cause of es 2 No
of Vital Records, ng Physician: The law requir	Be C	25. Was case referred to medical examiner?	26.Place of Death (Checkent 3 DOA Other Nursi		Residence 6 ✔ Othe	s: Coope
of Virtual of Physical Citer this	. To	1 V Yes 2 No 1 Impatient 2 ENOutpate 27. Manner of Death 28a. Date of Injury 28b. Time of	THE SECOND THE SECOND	28d. Describe h	now injury occurred	1. Ocene
Division tal or Attendii rs after death. ral Director: A	Certification:	1 Natural 5 Pending Apr 29, 2009 1518 hrs	1 Yes 2 ✓ No	Subject shot		ural Route Number, City
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Division of Northending Physical Acteuding Physical 24 hours after death.  To the Funeral Director: After templetely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ				
To th within To th comp	Medical	29b. Signature and title of certifier	29c. License number	a. a.o anio, date e	29d. Date signed (Mo	
OCME		Allen Seaself No)	O.C.M.E.		April 30, 2009	
3		Nam and address of person who completed cause of death (Item 23a)     Melissa Brassell, MD    Assistant Medical Examiner	Penn Street, Baltimore, MD	21201		
	tate	31. Date filed (Monthi, Day, Year) 32. Resistrar's Signature	race			
Regist	trar	MAY 0 7 2009 Bure 8.	with			

09-03496	
John Simmons	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MD NA Baltimore    NA   Baltimore	n Simmons		- For State Registrar	Department of I Certificate of L	Health and Mental H Death	Reg. N		9 147
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American Survey State    the Ma 3a or 28 otified a		422 North Glover Stree	t	21205				
22. Name and Address of Feath (The Price of Service Locarse)  23. Sprant L. Fine the disease, or Approximate Infantive. Use only one cause on each line.  24. Sprant Letter the disease, or Approximate Infantive. Use only one cause on each line.  25. Frant L. Fine the disease, or Approximate Infantive. Use only one cause on each line.  26. Frant L. Fine the disease, or Approximate Infantive. Use only one cause on each line.  27. Sprant L. Fine the disease, or Approximate Infantive. Use only one cause on each line.  28. Frant L. Fine the disease, or Approximate Infantive. Use only one cause on each line.  29. Smoke and soot inhalation and thermal injuries  29. Smoke and soot inhalation an	er death with, or items 2, cr must be n	Funera	1 X X Never Married 2 Married Armed Forces?	If Yes	s, specify Cuban, Mexican, Puerto		White, etc.A f	rican
22. Name and Address of Facility y 1 is Funeral 1 Home P.A.  23. Fart I. Enter the disease or Acomplications that caused the death. Do not enter the mode of giving, such as cardiac or respiratory arrest, shock, or heart feducine. List only one cause on each line.  23. Fart I. Enter the disease or Acomplications that caused the death. Do not enter the mode of giving, such as cardiac or respiratory arrest, shock, or heart feducine. List only one cause on each line.  24. Fart I. Enter the disease or Acomplications that caused the death. Do not enter the mode of giving, such as cardiac or respiratory arrest, shock, or heart feducine List only one cause on each line.  25. Fart I. Enter the disease or Acomplications that caused the death. Do not enter the mode of giving, such as cardiac or respiratory arrest, shock, or heart development of the feducine death. Do not enter the mode of giving, such as cardiac or respiratory arrest, shock, or heart development and the feducine development of the feducine	ours afte	至	or Dates:	oleted) 16a. Decedent's	s Usual Occupation (Give kind of			dustry
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28. Was decedent pregnant in the past 12 months?    Twestign   Twe	e execution of cian and cian and irial - tra	dical	X UNPENDED AMENDED 23	a,2/,28a-t, <sub>]</sub>	perME g891 5/12	/09 TT		
29b. Signature and title of certifier  29c. License number  O.C.M.E.  May 2, 2009  30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  37 Registrar's Signature	ox 68760 ath certificate b attending physi or use as the bu	sician/Me	23b. Was decedent pregnant in the past 12 months?	2 Feta				ay Year
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Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 37. Registrar's Signature	FSES	Me	29b. Signature and title of certifier	in	1	į.		nth, Day,Year)
State 31. Date filed (Month, Day, Year) 37 Registrar's Signature			30. Name and address of person who completed cause of d	eath (Item 23a)	Street, Baltimore, MD 212	L 01		
Registrar MAY 07 The Chause of Marie							<del></del>	
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			State of Ma	aryland /		rtment of F tificate of I			eg. No.?	0.0	11.757
			Registrar  1. Decedent's Name (First, Middle, Last)			incate or i	Jean	2. Date of Deat	th	UJ.	3. Time of Death
	Physici: /Medic		George Schneck					Month 05	05 2	Year 2009	19:05 PM
	Examin		4a. Facility Name (If not institution, give street and number)				Location of Death		4c. County Anne		dal
	Funeral		Baltmore Was hington Hospita  5. Social Security Number 6. Sex. 7. Ag	ge (In yrs. last b		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			
	Director		5. Social Security Number 212-03-8093 6. Sex 1 ☐ M 2 ☐ F 7. Ag	90	Yrs.	Months Days	Hours Min.	Nov. 2,	1918	Cour	lace (State or Foreign try) MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Loc	ation				1	0d. Inside City Limits
	Mary a-f she	tor	MD Anne Arundel	Linth	hicum	i					1 □Yes 2 No
	or 28	Direc	10e. Street and Number			10f. Zip Code		1	0g. Citizen of		try?
	s 23a	<b>Funeral Director</b>	427 Shipley Road  11 Marital Status 12. Was Decedent	Ever in II S	12 W	21090	ionania Origin? (Si	nogify Vos or No-	U.S.A.	ce - Americ	an Indian
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, i'm Medical Eventinar must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes, Give Year or Dates:		- 1	Yes, specify Cuba	ispanic Origin? (Sin, Mexican, Puerti Specify:	o Rican, etc.)		ck, White, e	
21215-0036	hin 72 ho e. <b>an "natu</b> l Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5		(Give k life. D	O NOT use retired	during most of wor d)	king	16b. Kind of B		
121	led wil Hygien her th	Con			Mach	ine Oper		ne (First, Middle, I			Lectric
and	d be fi ental F ked ot c evel	To Be	17. Father's Name (First, Middle, Last) George B. Schneck				Irene B		vialuen Suman	116)	
Maryland	shoul and M s marl	Ĕ	19a. Informant's Name/Relationship (Type. Print)	19	9b. Mailing	Address (Street	and Number or Ru	ral Route Number	r, City or Town,	, State, Zip	Code)
<u>ک</u>	and 2 lealth m 27 i		Mr G. William Schneck /Son				Lake Ro				
Baltimore,	ages 1 int of H t: If ite / or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State			ition (Name of atory or other plac rk Cemet		11,	20c. Location · Baltimo	•	
altin	mit. P. sartme sortani linjury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Loude			ss of Facility Si				
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			23a. Part 1. Exter the disease, or complications that caused shock, or neaf failure. List only one cause on each li	the death. Done.	o not ente	r the mode of dyir	ig, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
Shape !	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a consequence	o of):					_	4 obys
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	ed sit	iner	cause. Enter Underlying	a consequence	e offi						
	execut al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as	a consequence	e of):						
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O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending the completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	2 Fetal dea		Ectopic pregnanc Other (specify) _	у			ite of delive onth	ery Day Year
σ.	uires that the de	by Ph	Part II. Other significant conditions contributing to death b	ut not resulting	in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to the	ne cause of death?
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Sec.	e law r has be e 2 sh	Completed	pulmonary fibrosis					24a. Was a	sy	prior to co	psy findings available mpletion of cause of
a E	n; The ficate r, pag		Congestive heart failu 25. Was case referred to medical	re_					2 <b>(2</b> No	death? 1 ∐Yes	2 X No
<u> </u>	ysicia is cert directo	o Be	examiner?	ent 2 🗆 ER/0	Outpatient	3 □ DOA Oth	or:	th <i>(Check only on</i> ome 5 ☐ Reside		her (Specif	······································
Division of Vital Records, P.O.	nding Physician, The sth. r. After this certificate he funeral director, page	ation: T	27. Manner of Death  173 Natural  5 Pending investigation  28a. Date of Inju (Month, Da	ıry 28b	Time of Injury	28c. Injur Worl		28d. Describe ho			
Divis	tal or Atters as after de al Directo ed in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et	ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (Si City or Town		ber or Rura	al Route Number,
	the Hospi nin 24 hou the Funer	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner street.	of examination a	lge, death and/or inv	estigation, in my o	pinion, death occu	rred at the time, d	date and place,	and due to	the cause(s)
	Vitt vitt	2	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signe	1	-
	0 1		3Q. Name and address of person who completed cause of d	leath (Item 23s	a) (Type P	rint)	00103		05/05	120	· /
1	VV					e Glen	68123 Burnie, F	ND 210	16(		
	Sta Registra	_	DANICA NOVACIC 301 HOS  31. Date filed (Month, Day, Year)  NAY 07 2009  32. Registr	ar's Signature	and the						

DHMH 17 Rev 1/2001

**Physician** /Medical **Examiner** burial-trai Division or Vital Records, P.O. Box 68760

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**Physician** 

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or

Directo

Funeral

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Completed

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Baltimore, Maryland 21215-0036

attending phy d for use as the Certification: To

Examine

Physician/Medical

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Completed

Be

6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Baltimore MD

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29a. Certifier (Check only

> 29c. License number D68094

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) April 27, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUR MD 31. Date filed (Month, Day, Year) 2434 West Beiveder Avenue 32. Registrar's Signature

MO

**ORIGINAL** 

State Registrar

DHIVIN 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	ide City Limits M∡es 2 □ No
Physician /Medical Examiner  4a. Facility Name (If not institution, give street and number)  Funeral Director  Funeral Director  A. Facility Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sountry) Months Days Hours Min. (Month, Day, Year) 07/10/1960 Maryland.	de City Limits  Yes 2 □ No
4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	ide City Limits M∡es 2 □ No
Funeral Director  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 48 Yrs. Months Days Hours Min. (Month, Day, Year) 07/10/1960 9. Birthplace (S. Country) Months Days Hours Min. (Month, Day, Year) 07/10/1960 Maryland	ide City Limits Mg∕es 2 □ No
Director  220-76-8993  Usual Residence of Decedent  1 M 2 TF 48  Yrs. Months Days Hours Min. (Month, Day, Year) Country)  7 To Months Days Hours Min. (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month)  7 To Months Days Hours Min. (Month, Day, Year) (Months)  8 To Months Days Hours Min. (Month, Day, Year) (Months)  9 To Months Days Hours Min. (Month, Day, Year) (Months)  1 M 2 TF 48  1 M 2 TF	<b>X</b> es 2□No
Usual Residence of Decedent	<b>X</b> es 2□No
Maryland    State   St	<b>X</b> es 2□No
The street and Number  3402 Virginia Avenue  10e. Street and Number  3402 Virginia Avenue  11. Marital Status 11. Mever Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 11. Mescar Armed Forces? 11. Mescar Armed Forces? 11. Mescar Armed Forces? 11. Mescar Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Individual Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  16b. Kind of Business/Industry  Medical	an,
3402 Virginia Avenue  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Not Divorced 1 Note: The state of the specific property of the spec	an,
11. Marital Status 1   Never Married   12. Was Decedent Ever in U.S. Armed Forces? 1   Never Married   2   Married   1   Never Married   1   Never Married   1   Never Married   2   Married   1   Never Married   1   Never Married   1   Never Married   2   Married   1   Never Married   Never Married   1   Nev	an,
1 Never Married 2 Married 1 Yes 2 No Specify:  Specify: Black  1 Never Married 2 Married 1 Yes 2 No Specify:  Specify: Black  1 Never Married 2 Married 1 Yes 2 No Specify:  Specify: Black  1 Never Married 2 Married 1 Yes 2 No Specify:  Specify: Black  Sp	
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Nursing Aid  Medical	
(Specity only highest grade completed)    College (1-4or 5+)   College (1-4or 5+)	
Nursing Aid Medical	
besign of the state of the stat	
18. Mother's Name (First, Middle, Maiden Surname)	
Programmer Smith  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Maurice Carland / Nephew 13808 Dawn Whistle Way, Bowie, Maryland 2072	
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State	
1 Mg Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)    Removal from State 4 Donation 5 Other (Specify)   Ring Memorial Pk. Ceme.   Donation 5 Other (Specify)   Pk. Ceme   Donation 5 Other (Specify)   Pk. Ceme   Donation 5 Other (Specify)   Pk. Ceme   Donation 5 Other (Specify)   Donation 5 Other (Specify)   Pk. Ceme   Donation 5 Other (Specify)   Donation 5 Other (Spec	
22. Name and Address of Facility The Derrick C. Jones F/H, 4611 Park Hots. Ave., Baltimore, Maryland	
	ximate al Between
Physician Immediate Cause (Final disease or condition Onset	and Death
/Medical resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions	
resulting in death) Last  Due to (or as a consequence of):	
believed a state of the control of t	
FFEMALE: 23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Da	Year
9 Unknown 9 Unknown 9 Part II Other significant conditions contributes to death but not reculting in the underlying course given in Part I.	
The state of the s	
1   Yes 2   No 3   Probably	4 🗌 Unknown
24a. Was an 24b. Were autopsy find	lings available n of cause of
D & g & g & autopsy inc	
1   Yes 2   No 3   Probably  24a. Was an autopsy performed autopsy performed leath?  1   Yes 2   No 1   Yes 2   Yes 2   No 1   Yes 2   Yes 2   Yes 2   Yes 3   Ye	
autopsy performed?    1   Yes   2   No   No   Hospital:   Management   Management   No   No   No   No   No   No   No   N	
autopsy performed?    The state of the state	
autopsy performed?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  28b. Time of Injury at Work?  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred	
autopsy performed/2   1   Yes 2   No   No   No   No   No   No   No	0
autopsy performed?    1   Yes   2   No	0
autopsy performed?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Time of Injury  28. Location (Street and Number or Rural Route City or Town, State)  28. Place of Injury - At home, farm, street, factory, office  28. Location (Street and Number or Rural Route City or Town, State)  28. Certifier (Check only one)  28. Place of Injury - At home, farm, street, factory, office  28. Location (Street and Number or Rural Route City or Town, State)	o Number,
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Date of Injury  28. Time of Injury at Work?  29. License number  28. Date of Injury  28. Date of Death (Check only one)  28. Date of Injury  3	o Number, use(s)
	o Number, use(s)
	o Number, use(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3:30 Frank Speca 2009 May 6 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 136 N. East Avenue 2/15/1013

Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland ortant: If them 27 is marked other than "natural", or thems 23a or 28a-f show injury or other traumatic event, the American Examiner coust by notified at Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien. Important: If Item 27 is marked other the any injury or other traumatic event, Ital. Once.

Physician

/Medical

Examiner

**Funeral** 

**Physician** /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760,

To the Funeral Director: A completely filled in by the fu	Medical Certificati	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigat 6
ne Funer	edical	29a. Certifier (Check only one)	12 Certifying 2 Medical Ex
To the	Me	29b. Signature and	title of certifier
10		30. Name and addr	\
Sta Registr		31. Date filed (Mon	th, Day, Year) 0 7 2009

5. Social Security Number 213-09-22		. Sex 1 <b>⊠</b> M 2 □ F	7. Age (In yrs. I	last birthday Yrs.	Months	r 1 Year Days	If Unde Hours	Min.	8. Date of B (Month, L	irth Year, 3 19		Inplace (Sta ountry) 'yland	_
Usual Residence of De			140- 01									I d O d I leasted	City Limite
MD 10a. State	b. County			y, Town or L timo:									e City Limits ′es 2 □ No
10e. Street and Number 136 N. E		venue			10f. Zi	p Code 212	24			_	itizen of What Co	ountry?	
11. Marital Status		12. Was Dec	edent Ever in U.	S. 13.	. Was Dece	dent of Hi	ispanic C	rigin? (Spe	ecify Yes or N Rican, etc.)	lo-	14. Race - Ame Black, Whit		١,
1 ☐ Never Married 3 ☐ Widowed 4 ☐			ve No		1 □Yes				, , , , , , , , , , , ,		Specify: Wh		
15 (Specify	. Decedent's only highest	Education grade completed)		16a. Dece	edent's Usu e kind of wo DO NOT u	ual Occupa	ation during mo	st of worki	ng	16b. l	Kind of Business	/Industry	
Elementary/Seconda		College (	1-4or 5+)		elwo					Ве	thlehe	m Ste	el
17. Father's Name (Fire Giuseppe			peca			i	18. Moti Ade]		(First, Middl Va	<sub>e, Maide</sub> aler			
19a. Informant's Name				19b. Mail	ling Addres	s (Street a	and Num	ber or Rura	al Route Num	ber, City	or Town, State,	Zip Code)	
Mrs. Pats	sy Spe	eca - W	ife	136	N. E	Cast	Ave	nue	Balti	mor	e, Mar	yland	l 21224
20a. Method of Disposi 1 X Burial 2 □ C 4 □ Donation 5 [	remation 3		State 20b. P	lace of Disp emetery, cre klawr	oosition (Na ematory or o	me of other place	e) rv		)ate - 2009		ocation - City or	. ,	
21. Signature				, 2	22. Name a	nd Addres	ss of Faci	ility Jos	seph 1	1. Z	annino	Jr.	
VO P	uf	3-									imore,		
23a. Part 1. Enter the c shock, or heart to Immediate Cause (Fin disease or condition resulting in death)	ailure.List	a. END	sach line. STACE	RE			_		or respiratory	arrest,			mate Between nd Death
g,		Due to	(or as a consequ	uence of):								16 40	-ARS
Sequentially list condit if any hard immediates. Enter Underlyin Cause (Disease or injust that initiated events resulting in death) Last	ng iry	c	(or as a consequ									10 10	
resulting in Ceanty Last		d	(or as a consequ	uence of):									
IF FEMALE: 23b. Was decedent proin the past 12 mo 1 □ Yes 2 □ N 9 □ Unknown	nths?	1 ☐ Live	tcome of pregna birth 2□Feta nant at time of d nown	I death 3	☐ Ectopic ☐ Other (s						23d. Date of de Month	elivery Day	Year
Part II. Other significa	nt condition	s contributing to d	eath but not resu			,	en in Part	t I.	23e. Dio	I tobacco	use contribute t	to the cause	of death?
CORONARS	1 ACT	GRY DI	SEACE	STA	ROKE				1 [	]Yes 2	2 □ No 3 □ F	robably 4	Unknown
					-				per	s an opsy formed? 2 2 N	prior to death?	completion	ngs available of cause of
25. Was case referred examiner?	to medical							ce of Death	(Check only				
1☐ Yes 2☑No			Inpatient 2				4     1	Vursing Ho	me 5 Re	sidence	6 ☐ Other (Sp.	ecify)	
27. Manner of Death 1 Natural 2 Accident	investiga		of Injury oth, Day, Year)	28b. Time Injury	of M	28c. Injury Work 1 □ '	yat <br Yes 2[		28d. Describe	e how inju	ury occurred		
3 ☐ Suicide 6 4 ☐ Homicide	Could no determine	ad Zoe. Place	e of Injury - At ho ing, etc. (Specif	ome, farm, si	treet, factor	y, office			28f. Location City or To	(Street a	and Number or F te)	Rural Route I	Number,
29a. Certifier 1 (Check only 2 one)	Certifying Medical Ex	Physician: To the taminer: On the tamen	e best of my kno pasis of examina oner stated.	wledge, dea tion and/or i	ath occurred investigation	d at the tir	ne, date pinion, d	and place, eath occurr	and due to the	ne cause( e, date ar	(s) and manner and place, and du	as stated. le to the cau	se(s)
29b. Signature and title	of certifier	117	1		29	c. License	e number	r		29d. D	ate signed (Mon	ith, Day, Yea	ır)
In	In	Hana	16-1	UD	1	-	203			M	16	2000	}
30. Name and address	of person wi	no completed caus	se of death (Item	1 23a) (Type	, Print)	Alilie	-11	1001	+ n.	-710	lore M	N 71	274
JENNIFE	25 11	MYNSHI,	2202 6	TOPKI	NS B	NYVIC	M (	MICH	C IBA	1 (1N	TOPE M	1) 4	10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 04-29-2009 12:00 A M Lorraine R. Taylor 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Forest Hill 1 Colgate Dr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-19-1922 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Min Country) PA 1 □ M 2 🗓 F 182-40-8017 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 No MD Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21050 1 Colgate Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Bertha Motzkus John Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daryle Middlekauff (Daughter) 607 E. MacPhail Rd. Bel Air, MD 21014 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Indian Gap Nat. Cem. 05-05-2009 | Annville, PA 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Disease Coronary Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26 Place of Death (Check only one) 1 her (Specify) rred

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

Be

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Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 25a or 28a-f show injury or other traumatic event, the Madical Evaration or ust by notified at once.

death with the Maryland

Saltimore, Maryland 21215-0036

Pages 1

and burial-tran attending physician for use as the buria cate has been signed by the page 2 should be detached the Hospital or Attending Physician: I hin 24 hours after death. the Funeral Director: After this certifica completely filled in by the funeral director,

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed

Be

Medical Certification: To

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

miner? Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other	4 Nursing Ho	me 5 Residence	6 □0
per of Peath Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work?	at es 2 □ No	28d. Describe how inju	Jry occu

27. Man 2 ☐ Accident 6 □Could not be 3 ☐ Suicide determined 4 ☐ Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number City or Town, State)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title certifier

29a, Certifier

29c. License number D 0063981 29d. Datę signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

M.0

Revolution St. Havre de Grace, MD

State Registrar

within 24 hours a To the Funeral L

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:55 a 2009 May 5 Madeline Till /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A St. Elizabeth's Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1916 Months Days 1 □ M 2**X** F Maryland Nov. 6, 92 **Director** 219-26-3387 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f shov r than "natural", or Items 23a or 28a-f sho the Modical Expositer must be notified at 1 ☐ Yes 2 🔀 No Director Baltimore Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21229 728 Warwick Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No <u>۾</u> Specify: 3 ☐ Widowed 4 ☐ Divorced USA Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil timent of Health and Mental H tant: If Item 27 is marked ott Jury or other traumatic even Lawrence Giglio Madeline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 728 Warwick Rd., Baltimore, MD 21229 Joan A. Branamen (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. Loudon Park Cemetery 5/11/09 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Hôme 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in ... Immediate Cause (Final disease or condition resulting in death) **Physician** Oypai /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 □Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

State Registrar (Check only one)

31. Date filed (Month, Da

29b. Signature and title of certifier

Maiden

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Choice lane

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	State Registrar  1. Decedent's Nam	ne (First, Midn	ile, Lasi	t)			Certificate of	Death	2. Date of De		102U	UJ	3. Tir	≒∳ me of
n il				Nancy		ader			April	30			8:	:55
r	4a. Facility Name (					hah		or Location of Det ${\sf tonsvil16}$		4	lc. County B <b>a</b> 1t			
	5. Social Security N	Number	6. Se			yrs. last birtho	day) If Under 1 Year	r   If Under 24 H	rs. 8. Date of Bi	av, Yea	ır)	9. Biri	thplace (S	
	215 01 Usual Residence of				90	,			01/18	719	14	ria	rylan	IU
_	10a. State	10b. County	4		100	c. City, Town o	r Location						10d. Insi	
Ulrector	Maryland	ļ	N/A			Balti				10 (	Citizen of V	14/1		Yes
	10e. Street and Nu	<sub>lmber</sub> Iewport	Δ 17.6	enue			10f. Zip Code	, 21211		rog. c	U.S.		outility :	
runeral	11. Marital Status	ewpor c		12. Was Dec		in U.S.	13. Was Decedent of If Yes, specify Cu		(Specify Yes or No	0-	14. Rac	ce - Ame	erican India	an,
	1 □ Never Mar	_		If Yes, G	2 <b>∑</b> No iive		1 ☐ Yes 2X No		erio nican, etc.)		Specify	ck, White		
ed by	3 🛛 Widowed			Year or I	Dates:	160 0	ecedent's Usual Occ			16h	Kind of Bi	W	hite	
Completed		15. Deceder cify only higher		de completed,		1 (0	ecedent's Usual Occ Give kind of work don ife. DO NOT use retir	ne durina most of w	vorking				muustry	
	Elementary/Sect			Collegé (	(1-4or 5+)	S	ecretary			1	etai.			
0	17. Father's Name	(First, Middle		Carmol.	o Mort	tillaro			ame <i>(First, Middle</i> arie Anto		_	_ ′ _	no	
2	40- 1-6	In man (D-1)												
	Jain Tr				in la	- 1	dailing Address <i>(Stree</i> Gwynnbroo							
	20a. Method of Dis			0			isposition (Name of crematory or other pi		Date				Town, Sta	
	1 🔀 Burial 2 4 ☐ Donation				i State		or other place of the control of the	i	/04/2009	Ва	ltimo	ore.	Mary	y1a
	21. Signature of F				<u> </u>	/	22. Name and Add	1	Gonce Fun					
	Ling	w M	30	rame	inu:	1/12	4001 Pit		nway Bal					
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sal Examiner	Immediate Cause disease or conditi resulting in death)	art failure / Lie (Final on onditions, ambuste erlying s	Conly of	b. Due to	each line.	imer's	t enter the mode of dy  NOMON	lying, such as card					Approx Interva Onset	ximat at Bet t and
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 7:15PM Madeline Watler Z 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) Harford Air r If Under 24 Hrs. Bel 7 If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 🛣 F 125-42-6911 June 26, 1937 Honduras Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, Its Modical Examinar must be notified at X⊓Yes 2 □ No Director Harford Abingdon Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21900 3821 Memory Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ∐Yes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Black Specify: Honduran 3 Widowed W Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic event, Its Ms. once. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Home Health Aide Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amibelle Johnson Fernando Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frazier Court, Joppa, Maryland21085 203 Adrian Smith 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-9-09 Lynbrook, New York Rockville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael P. margull 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be execuattending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No his certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Compatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2/2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral D Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie DOC53568 Upper Chesapeako 500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fren LONDSON MI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent Name (First, Middle, Last)
AFRED MA 2. Date of Death Month Day Year **Physician** MARCEL 30 6002 ADD I /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rolfmore Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Age (In yrs. last birthday) **Funeral** Months Days 219-80-0071 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or Items 23a or 28a-f show aminer must be notified at Yes 2 No MD To Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number death with 4616 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 2XNo 1 ☐ Yes Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur and injury or other traumatic event, the Medical. once. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) ComeastCa 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State 21. Signature of Fune al Service Licensee Norro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due (or as a consequence v): Hypertension /Medical **Examiner** Due to (or as a gons if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last equence of) Examiner Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ģ 2 No 3 Probably 4 dinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b, Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Patter death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier

Baltimore, Division or Vital Records, P.O. Box 68760 To the Hospital within 24 hours at To the Funeral C

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Maryland

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Registrar DHMH 17 Rev 1/2001

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State

(Check only one)

29b. Signature and title of certifier

MISMERHA

M-D

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print),

Back

29c. License number

3377

2401 W. Belveden tre, Baltimore, MB 21215

29d. Date signed (Month, Day, Year)

taril 30, 2009

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c&22perFH, C891,5/28/09, WS
State of Maryland / Department of Heafth and Mental Hygiene
Amend Items 23a,24,25 per dr. g891,05/07/09dhb
ar Certificate of Death

Reg. No. 2 0 1 - For State Registrar Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death AMOUTH **Physician** 200 Amanda Ways /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnis Anne Arundel 8. Date of Birth (Month, Day, Oct 21, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕏 F 32 218-17-5507 1976 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD Anne Arundel Pasadena 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8170 Belle Tower Cross 21122 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced "natural" Completed item 27 is marked other than "natur other traumatic event, "the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Robert Ways Dawne L. Wiles 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Dawne Ways/mother 8170 Belle Tower Cross Pasadena, MD 21122 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 □ Donation 5 ₩ Other (Specify) in ctots May 8,2009 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Singleton Functal & Cremation Ser 21. Signature of Euneral Prio Sensee Danector 21201 1 2nd Ave. Glen Burnie, Md. 21061 Baltimore, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause Final **Physician** MOMM disease or condition resulting in death) /Medical Due to (or as a consequence of): Respiratory Failure, Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Spina Bifida attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) s been signed by the s should be detached to 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sh 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Man ✓ r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITCHTE CHOPRA ANIL 7575 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene statement of Perina ab 19892 8/5/11 6 Perina cate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 1307 **Physician** Baby Boy Walters Baby Boy Watters 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CENTER PLITMORE OF MARYLAND MEDICIAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day/4)/25/09 **Funeral** Months Hours 1 X M 2 □ F infanr Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Exart, in a near built of once. 1 ☐ Yes 2 ▼ No MD Director Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 USA 2415 Jerusalem Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Jessica Walters Watters ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) University of MD Med Ctr 22 Green Street Baltimore, MD 21201 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state 21. Sign iture Roll 1 d Sirver Licensee ROll 1 d Wayd , State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** EXTREME PREMATURIA /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for t Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

BOY WATTER

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

Medical

29a. Certifier

29b. Signatur

RO S.

and manner stated.

29c. License number

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

21201

MD

of death (Item 23a) (Type, Print) 30. Name and address of person GREENE ST BACTEMORE BRANDI

32. Registrar's Signature

title of certifier

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State of Maryland /		artment of H		nd Mental	Hygiene Reg. No	2000	14770
Physic /Med		1. Decedent's Name (First, Middle, Last)  Toshva	Bri	nKer		2. Date of Month	. Da	y 2009	3. Time of Death 02:37 A M
Exam		4a. Facility Name (If not institution, give street and number)  The Johns Hopkins Hospital	t in the law A	4b. City, Town, or Baltimore				. County of Death	place (State or Foreign
Funera Director		5. Social Security Number  077−12−5284  088  Usual Residence of Decedent	Yrs.	Months Days	Hours	Min. (Mont	h, Day, Year) 31/192	Cou	ew York
e Maryland <b>8a-f show</b> iffied at	Director	10a. State 10b. County 10c. City, To West		ostead					10d. Inside City Limits 1X Yes 2 □ No
and 21215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Dire	10e. Street and Number 498 Hading Avenue  11. Marital Status 12. Was Decedent Ever in U.S.	13.1	10f. Zip-Code  1155  Was Decedent of H		in? (Specify Yes o	Uni	tizen of What Cou ted Stat 14. Race - Ameri	es
1036 burs after deal", or item	þ	Armed Forces?  1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🙀 No	Specify:	Puerto Rican, etc	.)	Black, White	etc.
21215-0036 d within 72 hours aff giene. er than "natural", or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired sineer	during most	of working		Kind of Business/I	
ed at be	To Be Co	17. Father's Name (First, Middle, Last) Samuel Brinker				r's Name (First, M		n Surname)	-
Ma and 2 s of the and 27 is trau	-	19a. Informant's Name/Relationship (Type. Print) Shirley Brinker - Wife		ng Address (Street Hading A	and Numbe	r or Rural Route N	lumber, City		
Page Page ment c		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	etery, crer Monte	osition (Name of matory or other place efiore Ce	m	Date 4/13/09	Pin	ocation - City or 1	
Balt permit. Departr Importe any injt		21. Signature of Funeral Service Licensee M01163  23a. Part 1. Enter the disease, or complications that caused the death. D		The mode of dvi				hapels I kville M	DC 20852
Physician /Medical	r	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)		,					Interval Between Onset and Death
Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ce of):		•				
760, Utable be executed sysician and the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C	ce of):						
x 68 certifica ding ph	Physician/Medical	d	eath 3	Ectopic pregnand Other (specify)	Эy			23d. Date of deli Month	very Day Year
Cords, P.O. Bo requires that the death been signed by the atter should be detached for	þ	9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting	ng in the i	underlying cause g	iven in Part I	. 23e.			the cause of death?
0 & 0 N	Completed						Was an autopsy performed?	24b. Were au prior to death?	topsy findings available completion of cause of
VITA sician: certifica irector, I	To Be Co	25. Was case referred to medical examiner? 1   Yes 2   No   Hospital: 1   Hospital: 2   EB/	/Outpatier	nt 3 DOA Oth	or:	of Death (Check of Sing Home 5	only one)	6 Other (Spec	2 No
DIVISION Of VITE or Attending Physician: after death. Director: After this certific in by the funeral director.	ertification: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident 28a. Date of Injury (Month, Day Year)	Bb. Time o Injury	of 28c. Injui			cribe how inju	ury occurred	
DIVIS  vital or Atte  urs after de  ral Directo  illed in by the	O	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of injury - At home building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowled			mo data and	City o	or Town, State	e) 	ral Route Number,
DIV To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(check only one)  2 Medical Examiner: On the basis of examination and manner stated.			opinion, dea		time, date a		e to the cause(s)
10		James Block  30. Name and address of person who completed cause of death (Item 2:	3a) (Type	RE'	5 00	00	A	oril 09	2009
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				600 North	Wolfe S	St, Baltimo	ore, MD, 21287
Regis	trar	APR 23 2009 Senera S.	frank	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAMEND#23a-IIperMD4/27/09, BMW, McCo Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Hilda Frances Benes April 2009 17 9:30 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bethesda Health and Rehabilitation Center Montgomery Bethesda HUnder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 22, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛣 F 578-50-3252 94 1914 Washington, D.C Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at MD 1X Yes 2 □ No Director Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 5721 Grosvenor Lane 20814 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🎛 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; if Item 27 is marked other tha any injury or other traumation. Secretary Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adolph Bode Catherine Faulkner ပ္ 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4802 Bolling Brook Pkwy North Bethesda, MD 20852 19a. Informant's Name/Relationship (Type. Print) Ulrich Abelmann/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
Geo. Wash. University 20a. Method of Disposition April 17 2009 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Geo. Was Medical Washington, D.C. 4 N Donation 5 ☐ Other (Specify) Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Smature Funeral Service Li 9013 Annapolis Road, Lanham, MD 20706 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 9 10 9 disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or acriying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical the yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 200 No P.0. the detached 9 Unknow ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ Seizure Disorder № No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate 1 ☐Yes 2 No Hospitai or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 22 Mg 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1/2/Watural 5 Pending investigation within 24 hours arter vec...

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CO

State Registrar Georg

ack

(807

2. Registrar's Signature.

Aug #103

Olreymo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.

140

23

31. Date filed (Month, Day, Year)

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Rockville

10f. Zip Code 20906

1 ☐ Yes 2 🛣 No

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

1-	For State Registrar			
1. D	ecedent's Name	(First.	Middle,	Last)

10a. State

MD

5. Social Security Number

10e. Street and Number

11. Marital Status

577-60-3240 Usual Residence of Decedent

Betty Jean Balkner 4a. Facility Name (If not institution, give street and number)

National Lutheran Home

10b. County

3423 Island Creek Court

1X Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Montgomery

15. Decedent's Education (Specify only highest grade completed)

Arthur Alexander Balkner

Bobart C Warman/Thurston

19a. Informant's Name/Relationship (Type. Print)

1 ☐ M 2 💢 F

College (1-4or 5+)

Certificate of Death

7. Age (In yrs. last birthday)

84

10c. City, Town or Location

Silver Spring

U	lie2	U	U	4	1	4	1
	No.						

<sup>Day</sup> 2009

1925

USA

4c. County of Death

Montgomery

10g. Citizen of What Country?

14. Race - American Indian,

Specify: White

Federal Government

16b. Kind of Business/Industry

3. Time of Death

Birthplace (State or Foreign
Country)

10d. Inside City Limits

1 ☐ Yes 2√☐ No

California

5:05 PM

2. Date of Death

8. Date of Birth (Month, Day, Mar 26,

18. Mother's Name (First, Middle, Maiden Surname)

Sara Lolla Robinson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3423 Island Crook Court Silver Spring

22,

April

Phy	sician
/M	edical
Exa	ıminer

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Profice Exertiver must be notified at

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

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Ex

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

- Silve	Robert 5. Weiner	/ 11 db ccc	7427 1310	III CICCI (	MIL DIIV	CT DDITIN	9, 110 20300	
	20a. Method of Disposition	20b. f	Place of Disposition (Na cemetery, crematory or	me of other place)	Date	20c. Location -	City or Town, State	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont		Arundel Cr	rematory (		Odenton	•	
	21. Signature of Funeral Service Lice	teleth mo	1251 Bever]	nd Address of Facility Home Crema y L. Hecki	cotte, P.A	. cLarks	ville, MD 2	210
1. C	23a. Part 1. Enter the Asease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.  Due to (or as a consection)	Tage A	de or dying, such as o	ardiac or respiratory	ments	Approximate Interval Betw Onset and D	ween Death
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b				4-4-		
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10000000000000000000000000000000000	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic			23d. Date Moi	e of delivery nth Day Ye	Year
þ	Part II. Other significant conditions	contributing to death but not rea	ulting in the underlying	cause given in Part I.	2		ibute to the cause of de	
Completed		<b>√</b>			24a. Wa aut pei 1 🗆 Yes	formed?	Vere autopsy findings a prior to completion of calleath?  ☐ Yes 2 ☐ No	avail ause
Be (	25. Was case referred to medical examiner?			26. Place	of Death (Check only	one)		
	1 Yes 2 No		ER/Outpatient 3 D	OA Other: 4 Nur	sing Home 5 ☐ Re	sidence 6 □Othe	er (Specify)	
ation:	27. Manner of Death  1 ☑ Natural 5 ☑ Pending 2 ☑ Accident Investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ N		e how injury occurre	ed	
Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factor	y, office	28f. Location City or T	(Street and Number own, State)	er or Rural Route Numb	ber,
Medical (		hysician: To the best of my knominer: On the basis of examinated and manner stated.						;)
N	29b. Signature and title of certifier	2/ W. Ka	vestr) 25	2000 License number	6	29d. Date signed	1 (Month, Day, Year) 23, 2009	7
	30. Name and address of person who	,						
ate rar	Charles W. Kares 31. Date filed (Month, Day, Year) APR 24	sh, M.D. 9701 V 2009 32. Jegistrar's Signa	eirs Drive	Rockville /	, MD 20850	)		
2001			ORIGINA					

DHMH

			For State Registrar		State o	i Maryia	na / Depa <i>Ce</i>	artment o rtificate d			nentai Hy	ygiene Reg. No.		7	14//3
	Physici		1. Decedent's Name	e (First, Middle,	Last) MARY	ELIZA	RETH	BRANT			2. Date of D Month April	Day		ar	3. Time of Death 4:10 A M
- day	/Medio Examir		4a. Facility Name (/	f not institution,			22411	4b. City, Tow	n, or Locat	ion of Death	_ Apr 11	4c.	County of D	eath	1.10 H
- "					rial Hos				lerich				Freder		
	Funeral Director		5. Social Security N 212–62–4	172	3. Sex 1 ☐ M 2 【X】F		s. <i>last birthd</i> ay) 56 Yrs.	If Under 1 Ye Months Da	ays Hou	irs Min.	8. Date of B (Month, D Nov 26	irth <i>bay, Y</i> ea <i>r)</i> 5, 19	52 Ma	Birthplac Country aryla	e (State or Foreign end
	pu ,		Usual Residence of	Decedent 10b. County		100 (	City, Town or Lo	action.						104	. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be mained at	tor	10a. State	Freder	ick		kersvil							100.	1 ☐ Yes 2 💆 No
	r 28g	irec	10e. Street and Nur					10f. Zip Cod	de			10g. Cit	izen of What	Country	?
	h witi	Funeral Director	8830 Eur	eka Lan	е			21793	3			USA			
	deat	ner	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	Was Decedent If Yes, specify (	of Hispanio	Origin? (Sp	ecify Yes or N	0-	14. Race - A	American /hite, etc.	
9	after or ite	F	1 🗆 Never Marri	ed 2🕅 Marrie		2 X No		n res, specify ( 1 ⊡Yes 2 <b>X</b> )			riloan, etc.)				
21215-0036	ours	Completed by	3 Widowed	4 Divorced	Year or D	ates:		10100 21	ito ope	ony.			Specify.WI	nite	
5-(	72 h 'natu	ete	(Spec	15. Decedent's	Education grade completed)		16a. Dece	dent's Usual Oo kind of work do DO NOT use re	ccupation one during	most of work	ing	16b. K	ind of Busine	ess/Indus	stry
121	ithin ne. <b>han</b> "	Ig II	Elementary/Seco		College (	1-4or 5+)		DO NOT use re Lfied Nu				Ноз	lthcar	ro	
	led w Hygie her ti				ant)		Cerci	TIEG N			e (First, Middl				
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<u> </u>	should and Me is marl aumati	မှ	19a. Informant's Na	ame/Relationshi	p (Type, Print)		19b. Maili	ng Address (St	reet and Nu	ımber or Run	al Route Num	ber. City c	or Town, Sta	te, Zip Co	ode)
S	and 2 s ealth ar n 27 is rer trau		Kimberly			-	i	Eureka							,
ē,	1 and 2 1 Health tem 27 i		20a. Method of Disp		daugneer		Place of Dispo				Date		ocation - City		ı, State
E S	Pages ent of nt: If i		1 ☐ Burial 2 ☐ 4 ☐ Donation		B ☐ Removal from	State W.	Arunde	el Crema	atory	04/2	4/09	Ode	nton,	MD	
Baltimore, Maryland	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tt		21. Signature of Fu			1-	GĈ	2Name and A	ddress of F	emation	n Servi	ice	P.O. I	30x 7	784
	20 E # 9		Deve	Sy L	Helit		25/ Be	verly I	J. He	ckrott	e, P.A.	. Cla	rksvi]	lle,	MD 21029
			23a. Part 1. Enter to shock, or hea		omplications that only one cause on e	caused the de each line.	ath. Do not en	ter the mode of	dying, suc	h as cardiac	or respiratory	arrest,		In	pproximate Iterval Between Inset and Death
	Physician /Medical		Immediate Cause ( disease or condition resulting in death)	(Final n	a		failu	re							DAYS
4	Examiner		, , , , , , , , , , , , , , , , , , ,	- 1	0.1	ostric	A .	Diff	irile	cal	itis			T	AYS
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Ö	The law requires that the death cer ate has been signed by the attendir age 2 should be detached for use	Physician/N	1 □ Yes 2 ↓ 9 □ Unknown	ZNo	9 ☐ Unkr		i dealii 51	☐ Other (specif	у)						
σ.	that ned b		Part II. Other signif	icant condition	s contributing to d	eath but not re	esulting in the u	nderlying cause	e given in P	art I.	23e. Did	tobacco	use contribut	te to the	cause of death?
rds	quires an sign uld be	q pe	Diabe	tes							1 🗆	Yes 2	□ No 3□	Probab	oly 4 Unknown
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of Vital Records,	The lav	Completed by							, .		aut per 1 □ Yes	opsy formed? 2 No	deat	r to comp :h? Yes 2	
/ita	Physician: The this certificate ral director, pag	Be (	25. Was case reference examiner?	red to medical					26. F	lace of Deat	h (Check only	one)			
÷	hysio this o	ူ	1 ☐ Yes 24 🖸	No			☐ ER/Outpatie	nt 3□DOA	Other: 4 [	Nursing Ho	ome 5 ☐ Re	sidence	6 ☐ Other (	Specify)	
	Ing Ing	ioi io	27. Manner of Deat 1 ☑ Natural	5 Pending		of Injury hth, Day, Year)	28b. Time o Injury		Injury at Work?	0 TN-	28d. Describe	how inju	ry occurred		
Sic	Attending ir death. ector; After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	t be	of Injury At	home form str		1 □ Yes	2 LI NO	20f Looption	(Ctroot or	ad Number o	r Pural F	Route Number,
Division	가 를 다	Certification:	4 Homicide	determir	ed 20e. Flace build	ing, etc. (Spe	home, farm, str cify)	eet, factory, off	ice			own, State		i nuiai n	noute wurnber,
_	urs urs era ille		29a. Certifier	1 Certifying	Physician: To the	e best of my k	nowledge, deat	h occurred at t	he time, da	te and place,	and due to th	ne cause(s	and manne	er as stat	ted.
	To the Hosp within 24 ho To the Fune completely f	Medical	(Check only one)	2∐ Medical E	xaminer: On the t and man	pasis of exami mer stated.	nation and/or ir	vestigation, in	my opinion	, death occur	red at the time	e, date an	d place, and	due to th	ne cause(s)
	vith To th	Σ	29b. Signature and	title of certifier	Facial	P:	i, MD		cense numi	ber			ite signed (M		
	1 -		14/		rauzi	NIZV	1,100	D62	2180			Apri	1 22,	2009	9
	of Fr		30. Name and addr	ess of person w	ho completed caus	se of death (It	em 23a) (Type,	Print)							-

2 EG

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Regina A. Bissonette April 22, 2009 8:50 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 16188 St. Anthony Road Emmitsburg 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days 1 □ M 2 🕽 F Months Hours Director 128-22-1402 81 Jul 2, 1927 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Frederick Maryland Emmitsburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 16188 St. Anthony Road 21727 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify: ģ white 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Finnegan Mary Nicholson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Antona Blvd., Centereach, NY 11720 Michele Halley, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 M Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2009 Calverton National Calverton, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 G me Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications tink caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Rosepsis **Physician** week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> of Colun LENCINCINDAN 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0035/52 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 100 5. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Marylan		artment of F				giene Reg. No.	711114	14775
			Decedent's Name (First, Middle	e, Last)					2	2. Date of De Month	ath Day	Year	3. Time of Death
	Physic /Medi		Michele Lynn H	urke					12	April	a 1	, 200	7 06:24 AM
	Exami		4a. Facility Name (If not institution				4b. City, Town, o			1	4c.	County of Dea	
	, A <sup>2</sup>		Washington Cou			last birthday)	Hager If Under 1 Year			Date of Bir	rth		Ington
	Funeral Director	1	213-86-5087	1 □ M X□ F	49	Yrs.	Months Days	Hours	Min.	B. Date of Bir (Month, Da arch 1	3, Year)	960 Ma	thplace (State or Foreign ountry)
			Usual Residence of Decedent								, .		
	rylan show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation Stown						10d. Inside City Limits 1 □ Yes ※□ No
	Ba-f s	ecto		ngton		nager					10~ Citi	zen of What C	
	d Z1Z13-UU36 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medicel Exentilizatings be recitified at	Funeral Director	10e. Street and Number	tiotom De			10f. Zip Code	742				nited :	
	leath ns 23	era	13041 Little Ar	12. Was Decede	nt Ever in U.	S. 13.1	Was Decedent of H		rigin? (Spec	ify Yes or No		14. Race - Am	erican Indian,
	ifter d		1 X Never Married 2 ☐ Marr	Armed Force	es?					icán, etc.)		Black, Whi	te, etc.
w	DUS Durs a rall', o	d by	3 Wildowed 4 Divorced	If Yes, Give Year or Date	es:		1∐Yes 2∭No	Specify	/:			Specify:	White
2	72 h 72 h	etec	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during mo	st of working	,	16b. Kir	nd of Business	/Industry
MCHCLE	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	lite. i	Never Wo					N/A	Δ
ξ.	filed Hygin	ပို	17. Father's Name (First, Middle,	Last)			MEAST MO		ner's Name (	First, Middle	, Maiden	·	
37	Iryland Z1Z15-UU3 should be filed within 72 hours nd Mental Hygiene, marked other than "natural", matic event, the Medical Exm	To Be	Samuel Breck	kenridge					E1	la Dro	onebu	ırg	
BURKE	Maryland 21215-UU36 Id 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Expuri		19a. Informant's Name/Relations				ng Address (Street						
	and 2 and 2 ealth m 27		Linda Mock / Au	ınt			East 6th	Stree					
	Saltimore, bermit. Pages 1 ar Department of Hea mportant: If Item any Injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal from Sta	ate C	cemetery, crer	sition (Name of natory or other place		Dat			cation - City o	
	ITIM it. Pa rtmen rtant: njury		4 Donation 5 Other (S	pecify)	Mt.		et Cemete		4/27/			Funera	Maryland
6	Baltimore, Ma permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any Injury or other trau once.		21. Signature of Funeral Service	Stauffe	7				•				, MD 21702
			23a. Putt Enter the di ea e, or shock, or heart failur List Immediate Cause (Final				-		s cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		as a conseq		FAILUR	E					2 MONTHS
•	Examiner				UMON								DAUS
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		de a concod								
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
9	cate be executed physician and the burial-transit	<u>E</u>	resulting in deathy case	Due to (or	as a conseq	uence of):							
9	physicate sthe	dical		d									
	Hospital or Attending Physician: The law requires that the death certific 4 hours after death.  Funeral Director: After this certificate has been signed by the attending p titled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregna	ancy						23d. Date of de	elivery
	Geath death death d for	icia	in the past 12 months? 1 □Yes 2 ☑No	4 ☐ Pregnar	th 2☐ Feta nt at time of o		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су 				Month	Day Year
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	INVISION OF VITAL RECORDS, P.O. I or Attending Physician: The law requires that the darker death.  Director: After this certificate has been signed by the tin by the funeral director, page 2 should be detached the page 2 should be detached the property of the property o		Part II. Other significant condition	ons contributing to deat	h but not res	ulting in the u	nderlying cause giv	en in Part	:L				to the cause of death?
Ī	COLGS, w requires to be signed should be	Completed by	ASTITMA	0 - 0	0.50	- ')				-	Yes 2[		Probably 4 Lunknown
	fec e law has b e 2 sl	age .	INTESTINAL	PSENDO OB	31 RW	etion				24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
	VITAL KE siclan: The la certificate ha rector, page 2			nsy						1 □Yes	2 No	1 □ Ye	s 2□No
	on or vital ding Physician: th. After this certifica funeral director, p	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2. ☑ No	Hoonitol	nationt 2 TH	ER/Outpatier	ot 3 🗆 DOA Oth	or.	ce of Death		•	6 □Other (Sp	oniful
	g Phy g Phy er this eral d	n:T	27. Manner of Death	28a. Date of	Injury	28b. Time o				3d. Describe			өспу)
	Vitending death. ctor: Aft y the fun	atio	1 Natural 5 ☐ Pendir Pendir investi	gation	Day, Year)	linjury	M 1 =	Yes 2	□No				
	r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be lined 28e. Place of building	Injury - At he , etc. (Specia	ome, farm, str	eet, factory, office		28	Bf. Location City or To	(Street an wn, State	nd Number or F	Rural Route Number,
i i	urs af	2	74	4					- 4			\	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the th	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	ng Physician: To the be Examiner: On the bas and manner	is of examina	owledge, deat ation and/or ir	n occurred at the to estigation, in my	opinion, de	and place, a eath occurre	nd due to the d at the time	e cause(s e, date and	d place, and du	ue to the cause(s)
1	o the vithin o the comple	Mec	29b. Signature and title of certifie	r			29c. Licens						nth, Day, Year)
	F>F0		> lu	MD			1006	2891	5		APRI	L DI	2009
•	2		30. Name and address of person	who completed cause	of death (Iter	n 23a) (Type,	Print)	HACA	ITH CA	NIER	1570 P	ENNSYLV	ANIA AVENUE
_			30. Name and address of person PAWINE DAV 31. Date filed (Month, Day, Year)	y RICHARD	5 m	TAGERS	TOWN, MB	, 2	1742	, , ,			
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Reg	istrare Signa	ature A.	back	1					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death

14776

			For State Registrar	State of Maryland	-	tificate of i		ieritai i i	Reg.	2003	14/10
	Physicia		Decedent's Name (First, Middle, Last)     TRAVER	LAW BERRY				2. Date of D Month MAY		Day Year	3. Time of Death 9:10 p M
Y	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of Death			4c. County of De	
·	alicis es la esta esta esta en la		Talbot Wing - He			Chester	_			Kent	
Ü	Funeral Director		082-05-8190	M 2□F 7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	Day, Ye	ar) 9. B 911 N€	irthplace (State or Foreign Country) EW Jersey
	w :		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Manyl f sho ied al	ro	MD Kent	Cho	stert	Dr. 70					1⊠Yes 2□No
	r 28a- notif	Director	10e. Street and Number	<u> </u>	STELL	10f. Zip Code	<u> </u>		10g.	Citizen of What (	Country?
	th with 23a o 1st be	a D	101 Heron Point			21620				U.S.A.	
	ems ser mu	Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	13.	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - An Black, Wh	nerican Indian, nite. etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		l ☐ Yes 2 <b>X</b> No	Specify:				White
ς. Ο	72 hc 'natu dical	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced (Give	lent's Usual Occup	eation during most of work d)	ring	16b	. Kind of Busines	ss/Industry
12	within	ldm	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			" nager/Con		n 1	Light &	Power
9	filed Hygic		17. Father's Name (First, Middle, Last)	<u> </u>		10202 120	18. Mother's Nam				
an	ld be ental ked o	To Be	Henry Titus Berry				Jessie	Muchmo	re		
Maryland	shou ind M s mar umat	-8	19a. Informant's Name/Relationship (Typ	pe. Print)	19b. Mailin	g Address (Street	and Number or Rui	ral Route Num	ber, Ci	ity or Town, State	e, Zip Code)
Ž	and 2 salth a 1 27 ls er tra		Nancy Tanner (d	aughter)		Military	•	shingto	on,	D.C. 2	0015
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ Ro	20b. Placemoval from State	ace of Dispo metery, crer	sition (Name of natory or other plac		Date		. Location - City	
Ĕ	. Pag tment tant:	0	4 ☐ Donation 5 ☐ Other (Specify)	Kei		mation	5/4/	09	Sı	nyrna, D	E.
Baltimore,	permit Depar Impor any in		21. Sign after Euneral Survice Liberary	M005		Name and Addre alena Fui 18 West (	ss of Facility neral Hom Cross St.	e of St Galer	tepl	nen L. S MD. 216	chaech 35
			23a. Rart1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death e cause on each line.	Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	TU ence of):	THRIVE					Onset and Death 3 Weeks
	Examiner		Se wentially list conditions b	CERVICAL	myl	ELOPAT	444				6 months >5 years
W-	pe sit	iner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of).			C 0. 41	700		> 5 years
	xecut and Il-tran	Examiner	that initiated events resulting in death) Last	O STEVAR Due to (or as a consequ		FIS CEI	CNICHE	5 ///0	<u></u>	· · · · · ·	2 Jeans
68760,	rificate be executed ig physician and as the burial-transit			` .	,						
9	ifficate g phy as the	ledical									
Вох	th cer endin	an/N	23b. Was decedent pregnant	3c. If yes, outcome pf pregnar 1□Live birth 2□Fetal		Ectopic pregnancy	v			23d. Date of o	
O,	The law requires that the death cer tte has been signed by the attendir page 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown		Other (specify)	,		-	Month	Day Year
S, D	es tha gned se det	by P	Part II. Other significant conditions con	tributing to death but not resu	ting in the u	nderlying cause giv	en in Part I.			1	to the cause of death?
Records,	requir been si should	eted							] Yes	K -	Probably 4 Unknown
H Rec	2 3 2	Completed						24a. Wa aut pei 1∐ Yes	topsy rformer	prior t d? death	
Vital	Atter ding Physician; r death. ector After this certific. by the funeral director,	Be	25. Was case referred to medical examiner?	ospital:		t all post Oth	26. Place of Dear				
	Phys r this ral dii	- T	1 Yes 2 No	28a. Date of Injury	R/Outpatier 28b. Time o	1 3 DOA	4 Nursing H			e 6 □Other (S <sub>i</sub> injury occurred	pecify)
o	ding h. Afte fune	ţi	Natural 5 Pending investigation	(Month, Day Year)	Injury	Wor	k? Yes 2∐No				
Division or	Hospital or Atter ding I 24 hours after death. Funeral Director After tely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location City or T	(Stree own, S	t and Number or tate)	Rural Route Number,
	as CV as O	Medical C	29a. Certifier (Check only one)  (Check only one)  (Check only one)	ician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, deat ion and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the tim	ne caus ie, date	e(s) and manner and place, and c	as stated. due to the cause(s)
	<b>To</b> the within 2 <b>To the</b> сощре	Me	29b. Signature and title of certifier	10		29c. Licens			29d.	Date signed (Mo	onth, Day, Year)
			> Huntl	11		Do	04158	/		5/4/	2009
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)			-		

DHMH 17 Rev 1/2001

State Registrar

Chestertown, MD. 21620

Helen A. Noble, M.D. 122 Speer Rd.

>1L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 14, 3:45 P. M April Maurie Louis Conlon 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Wilson Health Care Center Gaithersburg Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, )
NOV. 16, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🔀 F 93 Yrs. 1915 Massachusetts 011-16-8839 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Montgomery Gaithersburg 1 No 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 301 Russell Avenue 20877 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Guidance Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Ambrose Callahan Mary Isabelle McPhillip 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20508 Highland Hall Dr., Montgomery Village,MD 20886 Charles J. Conlon/Son 20b. Place of Disposition (Name of George Place) Light Committee Conference of Committee Commi 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2009 4 Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityColumbia Mortuary Services, P.A. 21. Signature of Funeral Service Licenses 9013 Annapolis Rd., Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final well disease or condition resulting in death)

**Physician** /Medical Examiner

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once.

**Physician** 

/Medical

**Examiner** 

MD

Director

Funeral

2

Be Completed

ပ

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

traumatic event, the Medical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Canyotiveheart for	rluce
Due to (or an consequence of:  Heral fullrellation	with
Due to (ur as a consequence of My Hill benth	ecceler export
Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown

Be Completed by Physician/Medical Examiner

Certification: To

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit completely filled in by the funeral director, page 2 should be detached for use as the burlan-transit

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month

23d. Date of delivery

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Year

25. Was case eferred to medical examiner?

autopsy perform 1 □ Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 □Yes

1 Yes 2 No 27. Mann of Death

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident 3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier VR hertourses

6 □Could not be

determined

04115

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

HROBERT BIRSCHBACH, UL

Registrar

31. Date filed (Month, Day, Year) 23



09-03178 Troy Cooper

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	· marytaria i	Certi	ificate of	Death		Reg	g. No. 2 {	0 (	9 147
Physicia ledical Examin	n/ er	Decedent's Name (First, Middle,Last)     Troy Lee Cooper						April 20, 20	Day Year 009		3. Time of Death 1914 hrs
		4a. Facility Name (if not institution, give Holy Cross Hospital	street and number)		4	b. City, Town, o Silver Sprir	r Location of Deat	th	4c. County of I		
Funeral Director			7. Age	(In yrs. las	t birthday) $48~_{ m Yrs.}$	If Under 1 Ye			` '	9. Birth Cour	place (State or Foreign htry) DC
Aaryland 28a-f show any 1 at once.	Ī	Usual Residence of Decedent  10a. State  10b. County  MD  Montgome  10e. Street and Number		l0c. City, T	own or Location	on  r Spring  10f. Zip Code			g. Citizen of What		1 Yes 2 X No
h the Ma 13a or 28	oire 	2714 Fenimore Road					20902		US	SA	
_ OF	by Fune	1 Never Married 2 X Married 3 Widowed 4 Divorced	Yes, Give Year or Dates:	X No	If Ye	es, specify Cuba $f Y$ es 2 $f X$ N	an, Mexican, Puert		14. Race - A White, 6 Specify:	etc. <b>Whi</b>	
1215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural",	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	,	during mo		e. DO NOT use re		Automoti		·
215-0 be filed w ntal Hygid rked othe	Be Co	17. Father's Name (First, Middle, Last) Norman Lee Cooper						ne (First, Middle, M ene Cecilia			
mb 2121; and 2 should be filealth and Mental I leath and mental I traumatic event, it		19a. Informant's Name/Relationship (Typ. Leslie Lloyd Crook /		r		,		Rural Route Num Berlin, MI		State,	Zip Code)
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other traumatic event, the Medium you other traumatic event, the Medium you other traumatic event, the Medium you was a second to the property of the Medium you was a second to the property of the Medium you was a second to the property of the Medium you was a second to the property of the Medium you was a second to the property of the Medium you will be a second to the property of the Medium you will be a second to the property of the Medium you will be a second to the property of the Medium you will be a second to the property of the Medium you will be a second to the property of the property of the Medium you will be a second to the property of the Medium you will be a second to the property of the Medium you will be a second to the property of the proper		20a. Method of Disposition  1 Burial 2 KK Cremation 3  4 Donation 5 Other Specify:		e cre	ematory or oth ropolita	n Cremato	ory Apr	Date il 22, 2009	1 LCALIN	ria,	VA
Balt permit. Departi Importi	33	21. Signatury of Funeral Service License	Cale		22.N	ame and Address ancis J O Univer	ss of Eacility Colling F Sity Blvd.	uneral Hom West, Sil	e Inc. ver Spring	, MD	20901
Physician /Medical xaminer	3			sm with	Ci <b>rr</b> hosis o		g, such as cardiac	or respiratory arre	st, shock, or heart		Approximate Interval Between Onset and Death
	ا <u>ه</u>	Sequentially list conditions, b	ue to (or as a conse							-	
d d	盲	cause. Enter Underlying Cause (Disease or injury that initiated C	ue to (or as a conse	quence of):							
execut an and al - tra	Medical E	X UNPENDED	AMENDED			<u> </u>					
Box 68760, s death certificate be ex the attending physician ad for use as the burial	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcom  1 Live birth 4 Pregnant at t		2 Fet	al death 3 ner (Specify)	Ectopic preg	nancy	23d. Date of do Month	elivery Di	ay Year
, P.O. B	by Phy	Part II. Other significant conditions		but not res	sulting in the u	nderlying cause	given in Part I.				ne cause of death?
cords, law require has been si	Completed					-		24a. Was a autop:	an 24b. We sy pri med? de	ere aut or to co ath?	opsy findings available ompletion of cause of
tal Rec	ψ.	25. Was case referred to medical examiner?				26.Pla	ce of Death (Chec		2 10 1	✓ Yes	2 No
of Vit	B P	1 Yes 2 No 27. Manner of Death	spital: 1 Inpatier		ER/Outpatient 28b. Time of Ir		Other: Nurs		Residence 6	Other:	
ion of tending Pl eath tor: After the funera	ation:	1 ✓ Natural 5 Pending 2 Accident Investigation	(Month, Day,Ye	ar)	eoo. Timo or ii		Yes 2 No				
Division spiral or Attendis ours after death reral Director: Afilled in by the fu	Certification:	3 Suicide 6 Could not be determined	20 a Place of Init	ıry - At hor	ne, farm, stree	t, factory, office	building, etc.	28f. Location (S or Town, S		or Rur	al Route Number, City
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	ह	29a. Certifier 1 Certifying Physicial (Check only one) 2 Medical Examiner:	n: To the best of my On the basis of examind manner stated.	knowledge ination and	e, death occur d/or investigati	red at the time, on, in my opinio	date and place, ar on, death occurred	nd due to the caus d at the time, date	e(s) and manner a and place, and du	s state e to the	d. cause(s)
	ğ	29b. Signature and title of certifier	ma marmor states.				nse number		29d. Date signed		th, Day, Year)
5	-	30. Name and address of person who co	inpleted cause of de	eath (Item 2	) 23a)	0.0	C.M.E.		April 21, 200	JB	
		Russell Alexander MD. A	ssistant Medica	al Exami	ner 111	Penn Stree	t, Baltimore, I	MD 21201			
Sta Registr	te ar	31. Date filed (Month, Day Year) 2009	2. Registrar	s Signatur	fack	1		OCM			

09-03116	
Frank John Chamb	erlain
Physician/	1- For Regis
M al Examiner	
	4a. F
Funeral Director	5. Soi
1215-0036  1 be filed within 72 hours after death with the Maryland anked Hygiene and Hygiene arked other than "natural", or items 23a or 23a-f show any vent, the Medical Examiner must be notified at once.  Be Completed by Funeral Director	11. Mar 10e. 3 11. Mar 15. Ele

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nn Char		rlain Sta I-For State	ate of Maryla				and M	/lenta	l Hygiene		20	09 147
		Registrar 1. Decedent's Name (First, Middl	- 1	Cert	tificate o	Death			2. Date of D	Reg. No	0	3. Time of Death
hysicia Examir	/	•							Month April 18	Day	Year	1548 hrs
LXUIIII		Frank J.  4a. Facility Name (if not institution	Chamber1a		ή	4b. City, Town	, or Loca	ation of E			4c. County of Dea	ath
		Frederick Memorial H		,		Frederic	<			l	Frederick	
neral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1	_	f Under 2		Birth(Mi	W/DD/YYYY) 9. E	Birthplace (State or
ector		217-96-4655	1 XM 2 F	33	Yr		Days I	Hours	Apri.	13,	1976	Country Maryland
		Usual Residence of Decedent										10d. Inside City Limits
w any		10a. State 10b. County		10c. City,	Town or Loca							1 Yes 2 X No
28a-f show d at once.	į	Maryland Frede	rick		Adamst		-			10g C	citizen of What Co	
r 28a ed at	Director	10e. Street and Number 2685 Lydia C	ourt			10f. Zip Cod 2171					United S	
23a o notifi		11. Marital Status		cedent Ever in U.S	S 13 W			ic Origin	? ( Specify Yes or			erican Indian, Black,
items ist be	uneral	1 X Never Married 2 M	arried Armed F	orces?					uerto Rican, etc.)		White, etc	
, or	ш ]	3 Widowed 4 Div	1 Yes	2 X No	1	Yes 2X	No sp	pecify:			Specify:	White
amin	d b	15. Decedent's Education (Spe	cify only highest gra	ade completed)		nt's Usual Occ			d of work done	16b	. Kind of Busines	ss/Industry
n "na	턀	Elementary/Secondary (0-12)	College (	1-4 or 5+)				) NOT US	e retired)		Emad	
er tha	Completed		+2			Supervi		4-11 - 4	Name (First Midd	la Majal		neering
marked oth		17. Father's Name (First, Middle					18.0		Name (First, Midd			
rvent	o Be	Grover Chamb  19a. Informant's Name/Relations			19b. Maili	ng Address (	Street an	nd Numb	Crystal . er or Rural Route	Jone Number,	S City or Town, St	ate, Zip Code)
t. If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	ř	Crystal Chambe		other		-			Adamsto			
If item 27 is her traumation	ŀ	20a. Method of Disposition		20b. F	Place of Dispo	sition (Name			Date	20	c. Location - City	or Town, State
t: If		1 Burial 2 XCremation		ITOTH State	crematory or o		±		//22/20/			. Wassalas d
Important: injury or oth	H	4 Donation 5 Other S 21. Signature of Funeral Service		51		Crema Name and Ad					<u>rederick</u> er Funer	Maryland
Import		/ author	Stoul	100		162	1 On	00551				ck. MD 2170
ician		232 Part I. Enter the disease, or	complications nav	caused the death.	Do not enter	the mode of d	ying, suc	ch as car	diac or respiratory	arrest,	shock, or heart	Approximate Interva Between Onset and
dical	1	failure. List only we cause Immediate Cause (Final disease	NA state I - I -	juries								Death
niner		or condition resulting in death)	-	a consequence of	f):							
	L	Sequentially list conditions,	b		£\.							
	i.	if any, leading to immediate cause. Enter Underlying Cause		a consequence of	1).							
.=	Examiner	(Disease or injury that initiated events resulting in death) Last		a consequence o	f):							
and - transit	a		d					_				
sician	gic	UNPENDED	AMENDED		<u> </u>		_					
After this certificate has been signed by the attending physician inneral director, page 2 should be detached for use as the burial	sician/Medic	IF FEMALE: 23b. Was decedent pregnant in t	ho -	, outcome of preg		etai death	3	Ectopic	oregnancy	1	23d. Date of deli Month	very Day Year
endin use a	cial	past 12 months?		gnant at time of de		Other (Specify				.		
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s beer shoul	Completed									Nas an autopsy	prior	e autopsy findings availab to completion of cause of
ate ha	oml									erforme (es 2		Yes 2 No
ertific stor, p	ø	25. Was case referred to medic	al			26.			Check only one)			-
this c	.o B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie		<u>`                                    </u>		Nursing Home 5			ther:
After	n: T	27. Manner of Death	28a. Da	te of Injury oth Day Year) 3, 2009	28b. Time of 1514 hrs	f Injury 280		at Work?	Motorcy	ribe how clist (	injury occurred collided with	car
tor:	atio		estigation					s 2 🗸	NO			
Director:	tific	3 Suicide 6 Cou	ald not be	ace of Injury - At h		·	ffice buil	ding, etc	or To	wn. State	e)	r Rural Route Number, Cit
within 24 flours arter dealin  To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification	4 L Homicide		Major Roa								Road, Frederick, MD
n 24 i he Fin detely	edical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the basiner:On the basi	est of my knowled	ige, death oc	curred at the til	me, date pinion. d	and place	ce, and due to the urred at the time.	cause(s date and	and manner as place, and due	stated. to the cause(s)
To the complet	ledi	29b. Signature and title of certif	and manne	r stated.			icense r					(Month, Day, Year)
	Σ	250. Signature and title or certif	A U	( 0 1			D.C.M.				April 19, 2009	
		Mayente	The J	nell	220)			-				
		<ol> <li>Name and address of person Margarita Korell MD.</li> </ol>	·	ause of death (Iten edical Examir		Penn Stree	et, Bali	timore	MD 21201			
		31. Date filed (Month Per Year		Registrar's Signat								

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

			For State Registrar	State of M	arylan		artment of H		d Mental Hy	giene Reg. No. 🤈 🗍	ng I	1.780
	Physici	an	1. Decedent's Name (First, Middle, La	ast) Clark					2. Date of De Month	Day 2009	3. Tin	ne of Death
~	/Medic Examin		4a. Facility Name (If not institution, gi 4410 Oglethorpe	ve street and number, Street	#60!		4b. City, Town, or Hyattsv	ille	Death	4c. County	of Death	s
24	Funeral Director		579-88-5075	Sex 7. A 1⊠ M 2□ F		ast birthday) 7 Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bir (Month, Da Feb. 2	ay, Year)	9. Birthplace (St Country) D. C.	ate or Foreign
	e Maryland a-f show tifled at	ctor	Usual Residence of Decedent  10a. State  D • C •  10b. County			, Town or Lo					1 🕱	de City Limits Yes 2 ☐ No
	with the	Dire	10e. Street and Number	total N	T 7		10f. Zip Code	1		10g. Citizen of		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	by Funeral Director	606 Quackenbos S  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.		2001 Was Decedent of H If Yes, specify Cuba	ispanic Origin an, Mexican, F	1? (Specify Yes or No Puerto Rican, etc.)	U • S o	ce - American India ck, White, etc.	
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natu the Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) Special Ed.	ducation ade completed) College (1-4or	5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired Tmprove	during most o	f working	1	essiness/Industry Employed	
and 2	d be filed ental Hyg ced other c event, i	To Be C	17. Father's Name (First, Middle, Las Henry Gibson	t)					Name (First, Middle		me)	
Maryl	d 2 shoul th and Me 7 is mark traumati	ř	19a. Informant's Name/Relationship Barbara Gibson	(Type. Print) (Mother	)	19b. Mailir	ng Address <i>(Street</i> Qu <b>a</b> ck <b>en</b> bo	and Number	or Rural Route Numb et N.W Washing	ner City or Town	, State, Zip Code)	
ē,	s 1 an f Heali tem 2 other		20a. Method of Disposition	•	20b. F	lace of Dispo	osition (Name of matory or other place		Date	20c. Location	- City or Town, Sta	te
<u>m</u>	Page nent o ant: If ury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec				ke Cremat		/18/2009	Beltsv	ville, Md	•
Balt	permit. Departr Import. any Inj.		21. Signature of Fundral Service local	elyCCO.	25	7 3	447 l4th	Street	eral Home,	ashingt	o <b>n,</b> DC 20	0010
	Physician /Medical		23a. Part I. Enter the disease, or construct, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. End St	age R	enal D		ng, such as ca	ardiac or respiratory a	arrest,	Interva	kimate al Between and Death
30,	Examiner	l Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Acquir Due to (or a	ed Im	unodef	ici <b>en</b> cy S	Sy <b>n</b> dron	ne			
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 🗆 Feta	ıldeath 3∐	□Ectopic pregnanc: □ Other (specify)	<i>y</i>			ate of delivery onth Day	Year
<u>α</u>	quires that n signed b ıld be deta	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cause giv	ren in Part I.			tribute to the caus	
Il Records,	sician: The law requir s certificate has been si irector, page 2 should	Completed						.7		s an 24b. opsy ormed? 20 No	Were autopsy find prior to completion death? 1 ☐ Yes 2√2 No	n of cause of
or Vital	Physiclan: r this certifica ral director, p	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	iont 3 🗆	EB/Outpotio	nt 3 DOA Oth	or:	f Death (Check only		hor (Caority)	
	ilng Phy  After this funeral d	ation: To	27. Manner of Death  1 🔀 Natural 5   Pending 2   Accident investigation	28a. Date of In (Month, D	jury	28b. Time of Injury	of 28c. Injur			how injury occu		
Division	al or Atte safter des I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	Zoe. Flace of it	njury - At he etc. <i>(Specif</i>	ome, farm, st	reet, factory, office			(Street and Num own, State)	ber or Rural Route	Number,
Λ	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		Physician: To the bes aminer: On the basis and manner:	of examina							iuse(s)
4	To th To th	Me	29b. Signature and title of certifier	1 1	1		29c. Licens				ed (Month, Day, Yo	ear)
		'	~ ful	VI	1_			36562		April :	17, 2009	
	2		30. Name and address of person wh	9			Print) et, N.W.	Washi	ngton, D.	C. 2000	9	
架	Sta Regist		31. Date filed (Month, Day Year) APR 2 4 2009		traris Signa		,	, we set to be	D, D*			

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month OMAS COUPTNEY APRIL 21 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOSPITAL SECOURS BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Days INDIANA 2-10-Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22 5. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status UNK Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: WhITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

WNK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

BACTI MORE, MD

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

ρ

Completed

Be ဂ္ UNK

19a. Informant's Name/Relationship (Type. Print)

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Department of Health and Mental Hygiene Information of Health and Mental Hygiene Information in Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at agree. Once.

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

	20a. Method of Disposition	20b. Place of Disposition ( cemetery, crematory	Name of	Date	20c. Location - City or	Town, State
	1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	W ARUNDEL CRE	-MATTIQY	4-24-09	ODENTON, N	ID-
	21. Signature of Juny al Service Licens		and Address of Fac	ility DAUGUSATY	FUNERAL L	
	Mil Xahung	26011	<b>LOUNTAIN</b> R	D. PASATIENA	MD. 2112	
	23a. Part 1. Enter the disease of complications that caused it shock, or heart failure. List only one cause on each line					Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition a.	MYOCAR	DIAL I	NFARE	770N	
	resulting in death)  Due to (or as a	consequence of):				
	Consideration line conditions					
	Sequentially list conditions, if any school to innect the control of the conditions	consequence of):				
	cause. Enter Underlying Cause (Disease or injury that initiated events					
		consequence of):				
	0					
9	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  23c. If yes, outcome or  1 □ Live birth 2  4 □ Pregnant at t 9 □ Unknown	Fetal death 3 Ectop	ic pregnancy (specify)		23d. Date of de Month	livery Day Year
•	9 ☐ Unknown					
	Part II. Other significant conditions contributing to death but			t I. 23e. Did	tobacco use contribute to	o the cause of death?
	CHARDNIC OBSTRUCTIVE PO	LOUGHTY	DISEASE	1 🗆	Yes 2 No 3 √	robably 4 Unknown
				24a. Was	an 24b. Were a	utopsy findings available completion of cause of
				perf 1 □ Yes	ormed?   death?	s 2 No
	25. Was case referred to medical examiner?		26. Pla	ce of Death (Check only	one)	
	Uccnital:	t 2 ER/Outpatient 3	DOA Other: 4	Nursing Home 5 ☐ Res	idence 6 □Other (Spe	ecify)
	27. Mannerof Death 1 Natural 5 Pending (Month, Day, 2 Accident investigation	Year) 28b. Time of Injury M	28c. Injury at Work?	28d. Describe	how injury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur- building, etc.	y - At home, farm, street, fac (Specify)	tory, office	28f. Location City or To	(Street and Number or R wn, State)	ural Route Number,
	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of 2 ☐ Medical Examiner; On the basis of and manner state	examination and/or investigation	red at the time, date tion, in my opinion, d	and place, and due to the	e cause(s) and manner a , date and place, and du	is stated. e to the cause(s)
Ì	29b. Signature and title of certifier		29c. License numbe	r	29d. Date signed (Moni	th, Day, Year)
	Formelin, mi	2	D3027	2	ARRIL 21, 2	009

State Registrar HOSP

COURS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

5

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apr 30, 2009 **Physician** Norma Jean Catlett 5:15pm™ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golden Living Center Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Nov 17, 1935 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ ⋤ 289-32-6539 MD 73 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Allegany MD Cumberland 1 □ ¥es 2 □ No ral", or items 23a or 28a-f sh Examiner must be notifled Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 11824 Amherst Avenue 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 □ **X**o Baltimore, Maryland 21215-0036 2 Specify: 3 Widowed 4 Divorced white "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Keeping Memorial Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harrold Ambrose Nettie Twigg ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11824 Amherst Avenue Cumberland MD 19a. Informant's Name/Relationship (Type. Print) Robert Catlett 11824 Amherst Avenue MD 21502 husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 5/1/2009 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica 22. Name an Scarpelli Fulleral Home, PA Licen ee 108 Virginia Avenue: Cumberland, MD 21502 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the disease shock, or heart failure. Immediate Cause Final **Physician** disease or condition resulting in death oronam /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed siclan and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 625 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Dr

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 _ State		State o	of Maryl	-	artment of				/	2000	11700
		_	Registrar  1. Decedent's Name (i	First Middle La	et)		Ce	rtificate of	Deal	uri	2. Date of De	Reg. No.	2009	3. Time of Death
	Physicia /Medic		George B.		31/						0'2nth	13	2009	
	Examin		4a. Facility Name (If no	_	re street and nu	ımber)		4b. City, Town,		on of Death			ounty of Deat	
			5. Social Security Num		Pav	7 Age (In	yrs. last birthday	Rockvi.		der 24 Hrs.	8. Date of Bir	rth	ntgome	
	Funeral Director		579-36-005		<b>1X</b> M 2□ F	78		Months Day			2/28/1	931	Co	hplace (State or Foreign untry)  DC
	pu. N		Usual Residence of De	ecedent 0b. County		100	. City, Town or L	ocation						10d. Inside City Limits
	/aryla	jo		Montgon	erv		Olney	ocation						1 <b>X</b> Yes 2□No
	r 28a-	irec	10e. Street and Number				J	10f. Zip Code				10g. Citize	n of What Co	untry?
	th with 23a o	ralD	3333 Megai	ns Way				20832				Unite	d Stat	es
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. I've Medical Event hat the halffied at once.	by Funeral Director	11. Marital Status 1 □ Never Married 3 ☒ Widowed 4 [		If Ves G	orces? 2 ☐ No		Was Decedent of If Yes, specify Cu 1 □Yes 2X N	ıban, Mex	ican, Puerto	ecify Yes or No Rican, etc.)		. Race - Ame Black, White pecify: <b>B1</b>	e, etc.
2-0	72 ho	Completed	(Specify	5. Decedent's E only highest gra	ducation ade completed)		16a. Dece	dent's Usual Occ kind of work don DO NOT use reti	upation e during r	nost of work	ing	16b. Kind	of Business/	Industry
121	within lene. than	duic	Elementary/Seconda	ary (0-12)	College (	1-4or 5+)		national			-	Gov	ernmen	t
DC 2	al Hyg other	Be C	17. Father's Name (Fin		)		12				e (First, Middle	, Maiden Su	ırname)	
ylar	Menta Menta arked atic ev	2	Ralph Dine	8					l I	Mary B	rown			
Mar	12 shoth and 7 is m	1	19a. Informant's Name George B.			an.	1	ng Address (Stre 7 <b>Classi</b>						Zip Code) 20901
ق	f Heal f Heal tem 2 other	1	20a. Method of Dispos		31. /50			osition (Name of matory or other p			Date		tion - City or	
Ë	Pages nent o int; If i		1 XI Burial 2 □ 0 4 □ Donation 5			State	Gate of		iace)	4/20	/2009	Silve	r Spri	ing, MD
Baltimore, Maryland 21215-0036	permit. Departn Importa any Inju		21. Signature of Funds	ral Service Lice	hour	asar	2							Ice, Inc. DC 20012
			23a. Part 1. Enter the shock, or heart f	disease, or com	plications that	caused the deach line.						_		Approximate Interval Between
8	Physician	9	Immediate Cause (Fir disease or condition resulting in death)	nal	aM	ultip1	le Mye1o	ma						Onset and Death
1	/Medical Examiner		Due to (or as a consequence of):  Hypercalcemia											
		ē	Sequentially list condition if any leading to imme	tions, ediate	D. —		sequence of):							
)	ocuted nd transit	Examiner	cause. Enter Underlyi Cause (Disease or inju- that initiated events resulting in death) Las	ury 1	Ç		pathy							
	ficate be executed physician and s the burial-transit		resulting in death) Las	ST		,	sequence of): Fibrill	ation						
68760,	rtificate ng physi as the I	edical			d	CLIUL	TIDILLI	acton						
XO	th cert tending r use a	Physician/M	IF FEMALE: 23b. Was decedent pr		23c. If yes, ou	tcome of problems		☐ Ectopic pregna	ncv			23	d. Date of de	*
P.O. Box	the at	ysici	in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown			gnant at time		Other (specify)					Month	Day Year
٠ <u>.</u>	s that t ned by detac	by Ph	Part II. Other significa	ant conditions	contributing to	leath but not	resulting in the	ınderlying cause (	given in Pa	art I.	23e. Did	tobacco use	contribute to	the cause of death?
rds	en sig										1 🗆	Yes 2□	No 3□ Pi	robably 4 🙀 Unknown
ပ္ပ	law re nas be e 2 sho	Completed									24a. Was	an psy	24b. Were au	utopsy findings available completion of cause of
a F	Physician; The la										1 □ Yes		death? 1 □ Yes	2 □ No
=	/sicial	o Be	25. Was case referred examiner? 1 ☐ Yes 2 ☒ No		Hospital:	Innatient	2 ☐ ER/Outpatie	nt 3 DOA			h <i>(Check only o</i> nne 5□ Res		ClOther (Sne	ecify) Hospice
n of	fter thi	H- 1	27. Manner of Death	5 ☐ Pending	28a. Date		28b. Time of			1 runoning ra	28d. Describe			<i>(11)</i>
Sio	tendii leath. tor: A the fu	catio	2 Accident	investigatio 6 ☐ Could not b	n			M 1	□Yes 2	2 □ No				
Division of Vital Records,	I or At after c Direct	Certification:	4 ☐ Homicide	determined	28e. Place build	e of Injury ling, etc. (S)	At home, farm, st pec <i>ify)</i>	reet, factory, offic	е			(Street and i wn, State)	Number or Hi	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 (Check only 2 one)	X Certifying Pi ☐ Medical Exa	miner: On the	e best of my basis of exa- nner stated.	knowledge, dea mination and/or i	th occurred at the nvestigation, in m	time, dat y opinion,	e and place death occur	, and due to the red at the time	e cause(s) a , date and p	ind manner a lace, and due	s stated. e to the cause(s)
	Vithin Comp	Me	29b. Signature and title	e of certifier	1/ 1 -	10	40	29c. Lice	nse numb	er		29d. Date	signed (Mont	th, Day, Year)
	2041		Joset	yne	KOUC	rchi	ou, m	0 000	563	748			4/15/2	2009
			30. Name and address Jocelyne I						1 Ro	ad. Da	ockvi 11.	e MD	20855	5
	Sta	te	31. Date filed (Month,	Day, Year)	2.	Registrar's S	ignature		NO	in e in	CKVIII	C FID	2005.	,
	Registra	ar	APK	23 200	13 Klen	sugar.	A. Ba	Keel						

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be

	Registrar				Ce	ertificate	e of L	Death	7		Reg. N	No. 2 (	no	11.7	
an		ame (First, Middle	, ,							2. Date of D Month		Day One	Year	3. Time of De 2:05p	
cal ner	4a. Facility Nam	e (If not institution	n, give street and n	umber)		4b. City,	Town, or	Location	of Death	April		2009 4c. County	y of Death		
	2903 Da	Whea					Montgomery								
	5. Social Securit	7247	6. Sex 1 <b>XX</b> M 2□ F	Month Day Voor							9. Birth Cou	Birthplace (State or Fore Country)  PA			
tor	Usual Residenc 10a. State MD	10b. County  Monto	10c. Ci	ty, Town or I	ocation eaton						10d. Inside City Lim 1 □ Yes 2 🛣				
I Director	10e. Street and Number 2903 Dawson Ave.						Code 20902	2			10g. (	Citizen of	What Cou	untry?	
by Funeral		arried 2K Marr	Armed F 1 <b>XX</b> es If Yes, G	d Forces? If Yes, specify Cuban', Mexican', Puerto Rican, etc.) Black es 2 □ No , Give 1 □ Yes 2 【X No Specify: Specify:						ick, White	- American Indian, , White, etc.				
	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII						edent's Usual Occupation					Kind of E	W Business/I	hite ndustry	
Completed	Elementary/S	(Specify only highest grade completed) (Give kind life. DO N						nd of work done during most of working O NOT use retired) etronics					Federal Government		
To Be C	17. Father's Nar Anthor				ner's Nam <b>arie</b>	e (First, Middl Pappa	e, Maide	en Surnai	me)						
-	19a. Informant's			_		ral Route Num	_	y or Town	, State, Z	(ip Code)					
	Dorothy Ann DeLuca / Wife 2903 Dawson Ave., Wheaton, MD 20902  20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location 20b. Place of Disposition (Name of Date 20c. Location 20b. Place Date 20b. Place Date 20c. Location 20b. Place Date 20c. Location 20b. Place Date 20b. Place 20b. Place Date 20b. Place 20b. Pla									- City or T	Town State				
	1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Cate of Heaven Cemetery April 24, 2009 Silver Spring, MD														
	21. Signature of Funeral Service Lieunsee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901														
	23a. Part 1. Ent shock, or Immediate Cau disease or cond	se (Final	plications that one cause on					-						Approximate Interval Betwe Onset and De	
	resulting in dea	th)	a	o (or as a conseq		diovasc	ılar	Disea	se					Years	
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month HORIL Year **Physician** 2009 Diggs 0756 Gregory /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Nicomics SAUSBURY TENINSULA REGISNAL MEDICAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 🛛 M 2 🗆 F 55 05-19-1953 Maryland Director 579-70-1525 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a, State ir than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at 1 Nes 2 No Director Maryland Wicomico Salisbury the 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code with 523 Naylor St. 21801 USA Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 12 Landscaping ulth and Mental Hygi 27 is marked other r traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Catherine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Felicia Jackson/Mother 1204 Westview Terr.Laurel Maryland 20707 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton MD 4/21/09 Resurrection 21. Signature of Empera Service Licenses 22. Name and Address of Facility Adams Funeral Home PA, Aquasco MD 20608 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** of lope of La Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 5 Other (specify) signed by the a d be detached for P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending F after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) rtifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 €. A Carril 31. Date filed (Month, Day, Y 32. Registrar's Signature 723 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ester Ojeda de Diaz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 □ M 2 X F 12-30-1951 Director 214-77-1636 57 E1 Salvador Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Welferl Examiner must be notified at 1 Yes 2 No Directo MD Hyattsville Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8215 17th Avenue 20783 El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No If Yes Give Specify: 3 Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates salvadoran Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Housewife Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Marcelino Ojeda Maria C. Vasquez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8215 17th Ave. Hyattsville, Maryland 20783 Oscar Arcides Diaz (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Family Cemetery 04 - 30 - 09EL Salvador 5 ☐Other (Specify) 4 Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 3447 14th St. N.W. Washington DC 20010. 23a, ar 1. Ent of the disease, or complications that caused the death. shock, or heart failure. List only one cause on each liming diate cause (Final Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** ease or condition resulting in death) arasa /Medical Due to is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last -Olonax Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Ö been signed by the should be detached 9 Unknown 9 Unknown 4 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate Division of Vital director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2X ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 X Natural 5 Pending investigation , b, ,s after dea, ,eral Director; A' ,v filled in by the 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number

State Registra

32. Registrar's

Name and address of person who completed cause of death (Item 23a) (Type,

Print)

09-03455 Mary Arlis Early Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 14787

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Me	Physicia `Examii	in/ 1	egistrar . Decedent's Name (First, Mary Arli		Y								Date of Dea Month April 29,	Day 2009		ear	3. Time o 1314	
		4	a. Facility Name (if not insti	_	et and num	ber)		4	b. City, To Finksb		ocation of	Death		- 1	Carroll	y of Deat		
	Euporal		5. Social Security Number	6. Sex	7	'. Age (In y	rs. last bi	rthday)	If Under	1 Year	If Under		8. Date of B	irth(MM	/DD/YY	(Y) g. Bi Forei	rthplace (Si	ate or
	Funeral Director			1 M	2 <b>x</b> F	51		Yrs.	Months	Days	Hours	Min.	Sept	. 13	3, 1	9570	ountry)	MD
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	2121 ould be 1 Mental marke	To Be	James Lewis					19b. Mailin	g Address	(Street	and Num	ber or R	tural Route N	lumber,	City or 1	Town, Sta	ite, Zip Cod	le)
	AD 2 shou h and h and l 27 is r is numatic		19a. Informant's Name/Rela Denise Smith	- Daug	ghter								a, PA			on City	or Town S	tate
	Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 Burial 2 Crer	nation 3	Removal fro	om State	20b. Plac cren	e of Dispo	sition (Nan ther place)	ne of cen	netery,	M	ay tel,	200	9 Lucan	ctos	d MT	1
			4 Donation 5 Oth	er Specify:			Carr						• • •		Hampstead, MD neral Home & Chapel, F			
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Funeral Director		100 01 1100	7. Age (In yrs. last birtho	Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Apr 24,	9. Birthplace (State or Foreign 1916 New York, NY
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince G	George's Clinto			10d. Inside City Limits 1 ☐Yes 2 → XX
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nd 2 alth ar		Ellen Mack (sister	690	03 Groveton Drive.	Clinton,	
permit. Pages 1 al Department of Hee Important: If item any injury or othe once.		20a, Method of Disposition  1XXBurial 2 Cremation 3	20b. Place of D	Disposition (Name of crematory or other place) April	Date 27, 2009	20c. Location - City or Town, State
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permil Depar Impor any ir		21. Signature of Funeral Service Licens	mo1533	22. Name and Address of FacilityLee Alexandria Ferry Ro	Funeral	Home,Inc 6633 01d
Physician /Medical Examiner  pu	Examiner	23à. Part 1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)		Or Secu	Interval Between
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Attending death. ctor: After y the fune	Certification: T	27. Manner of Death  1	28a. Date of Injury (Month, Day, Year) 28b. Tir Inju	me of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe h	ow injury occurred  Street and Number or Rural Route Number,
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ä	29a. Certifier Certifying Ph	ysician: To the best of my knowledge,	death occurred at the time, date and place	rred at the time	cause(s) and manner as stated.
To the I within 2. To the f complet	Medical	29b. Signature and title of gertifier	and manner stated.	29c. License number		29d. Date signed (Month, Day, Year) 4/22/09 who was Hengber. XIMY
085		30. Name and address of person who	empleted cause of death (Item 23a) (T	Type, Print) 11701 Wingston	Road F	nt was kengton searry
Sta Registi	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	parke		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4/16/2009 **Physician** 12:49p M Lyles Edelen Nora /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George 8206 Poplar Hill Dr Clinton 8. Date of Birth (Month, Day 03/21/ 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕌 F Months Days Hours Min 96 Director 219-16-2437 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, its Medical Evaninar must by natified at 1 Yes 2 □ No Director Maryland Charles Bryantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20617-2225 USA 13280 Langley Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other than any Injury or other traumatic event, It alone. Domestic <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lyles Mary Reeves <u>Clarence</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23rd Parkway, Temple Hills MD 20748 James A. Edelen/ Son 3412 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) St.Marys Cath Ch | 4/22/09 Bryantown, MD 22. Name and Address of Facility 191 Adams Funeral Home PA, Aquasco, MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** year Dement disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disages or Ir ju that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) the detached 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has 2 **2** No certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ) Aught ita Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 053590 20 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N BROADWAY by MO 400M 609 SYDNEM 21205 BALTIMORE 31. Date filed (Month, Day, Year) APR 2 3 2009 32. Registrar's Signature State parke Registrar

			y <mark>pe or Print in</mark> State of Maryla				_	_	
		1 - State Registrar			rtificate of			Reg. No. 200	9 14791
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Mary Ann Farrin					2. Date of Dea Month April	Day Year 18, 2009	10:14 PM
Exami	ner	4a. Facility Name (If not institution, give s Southern Mary1  5. Social Security Number 6. Sex	and Hospital			r Location of Death  nton  If Under 24 Hrs.	9 Date of Biri		George's
Funeral Director			M 3AXF 68	s. last birthday) Yrs.	Months Days	Hours Min.	March March	9. Bi 27, 1941 Ma	ountry) aryland
he Maryiano 28a-f show ciffied at	Director	10a. State 10b. County  Maryland Prince Ge		ity, Town or Lo	andywine			10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once.	Funeral Dir	10e. Street and Number           10505 Cedarville           11. Marital Status	Was Decedent Ever in I     Armed Forces?		20613	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	United Sta	ates erican Indian,
hours afte	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【 Noticed  15. Decedent's Educ	1 □ Yes 2 □ No If Yes, Giva X Year or Dates:	16a. Dece	1 □ Yes 2 □ No	Specify:			nite
AIAIS ad within 72 ygiene. er than "na t, tre Madia	Completed	(Specify only highest grade Elementary/Secondary (0-12) 10th	Completed) College (1-4or 5+)	Melwo		during most of work d)		Superviso	or
Ital ylallu	To Be	Preston Joseph W		1 421 44 111		Lilli	an Regi	Maiden Surname) na Richards	
te, IMal stand 2 st ftealth and tem 27 is no other traur		19a. Informant's Name/Relationship (Type Phillip Gary Farr) 20a. Method of Disposition	ington	105		ville Roa		1-25, Brance 20c. Location - City o	
partition permit. Pages Department of i Important: If its any injury or o		1 ☐ Burial 2 🕅 remation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Sergics Appense	emoval from State	Lee Cr	emtory A	pril 21.	2009 Funera	Clinton, M 1 Home, Inc	Maryland
		23a. Part 1. Enty the disease, or complice shock, on earthailure. List only on	e cause on each line.	ath. Do not en	lexandria ter the mode of dyi	a Ferry R	oad, Cl	inton, MD	20735 Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Jause Final disease of condition resulting in death)	Due to (or as a conse	quence of):	ENAL	Dise	ASE		Admitted
xecuted and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	ENSIVE	E HEAR	1 Bise	ARE		Expired on 4.18.09
tificate be ex g physician as the burial.		d.	CORON		HRTER	1 DISE	32AS		at 11.05 pm
ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	☐ Ectopic pregnand ☐ Other (specify) _	cy		23d. Date of d Month	elivery Day Year
r requires that requires that been signed I	þ	Part II. Other significant conditions con	tributing to death but not re					obacco use contribute	to the cause of death?  Probably 4 Unknown
ar necon: The law ricate has be r, page 2 sh	Completed						1 □Yes	ormed? death? 2.⊠No 1 ☐ Ye	
To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ation: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	ospital: 1 Inpatient 2 [ 28a. Date of Injury (Month, Day, Year)	ER/Outpatie	f 28c. Inju Wor	4 LI Nursing H	ome 5□Resi	one) Idence 6 □ Other (Sp how injury occurred	necify)
Ital or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			City or To		
the Hosp thin 24 hou the Fune	Medical	(Check only 2 Medical Examin	ician: To the best of my kner: On the basis of examinand manner stated.	nation and/or ir		opinion, death occu			ue to the cause(s)
2 × 2 × 8		Laturh Jun	mploted cause of death (Ite	m 22a) (Tuno	D3	2532		4.19.0	9
BI	ate -	SATISH JUMAN 31. Date filed (Month, Day, Year)	32 Bedistrar's Sign	atrick	201108 2-	, Suite 2	208, iu	soldorf,	MD 20603
Regist		APR 2320	109 Jenus	B. 4	backer				

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	Cer	tificate of L	Death	Reg	. No.	
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	/Medic				et Jr			APRIL 1		
	Examin	er	4a. Facility Name (If not institution,	_		4b. City, Town, or Lanham	Location of Death		4c. County of De	
	Funeral	_	Doctors Hosp  5. Social Security Number	Oltal 3. Sex 7. Age (In yrs. i	ast birthday)		If Under 24 Hrs.	8. Date of Birth	Prince	Birthplace (State or Foreign
	Director		214-52-6918 Usual Residence of Decedent	1⊠ M 2□ F 61	Yrs.	Months Days	Hours Min.	(Month, Day, Y 1-5-19	48 Wa	shingtonDC
III Z I Z I 3-0030 be filed within 72 hours after death with the Marvland	show	_	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits 1 □XYes 2 □ No
ă Ž	8a-f	Director	Maryland Princ	e George Bra	indywi			1.10	0.00	
with	aor		10e. Street and Number			10f. Zip Code	1.2	109	j. Citizen of What	Country?
eath	ns 23	Funeral	13200 Poppy  11. Marital Status	Hill Ct.  12. Was Decedent Ever in U.	S. 13. V	206 Vas Decedent of H		pecify Yes or No-	USA 14. Race - Ai	merican Indian,
dier d	ir iten	Für	1 ☐ Never Married 2 🛣 Marrie	Armed Forces? d 1 Tes 2 No If Yes, Give		Vas Decedent of H		o Rican, etc.)	Black, Wi	'
	rall, o	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	□Yes 2⊠No	Specify:		Specify: B1	ack
2 %	f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment reast be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Deced (Give	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor	king [	b. Kind of Busines	ss/Industry
Mili K	than than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ervisor-	_		WSSC	
ע ק	Hygi other	C	1.2 17. Father's Name (First, Middle, La	ast)	Bupe	71301		ne (First, Middle, Ma	iden Surname)	
	ked c	m	Richard 0.		r_		Margare	et	Por	ter
and yie	and Mental Hygiene. Is marked other than aumatic event, tre III	_	19a. Informant's Name/Relationshi			g Address (Street	and Number or Ru	ral Route Number, C	City or Town, State	e, Zip Code)
3, W	of Health item 27 I r other tra		Arleta Fleet/	Wife	13200	) Poppy	Hill C	t.Brandy		
	iter Fiter or oth		20a. Method of Disposition  1. □ Burial 2 □ Cremation 3	20b. P	lace of Dispo: emetery, cren	sition (Name of natory or other plac			c. Location - City	
	tmen tant: jury		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			Ch. Cer		5/09 B	randywi	ine MD
parmit. Pages	Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Li			. Name and Addres		ome PA,A	quasco	MD 206008
			23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplicatio that caused the death						Approximate Interval Between
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	Adminici	<u>_</u>	Sequentially list conditions,	b. Due to (or as a consequ	ience of):	ANCER	resp	•		
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ath of	or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	death 3	Ectopic pregnanc	У		23d. Date of Month	delivery Day Year
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law re	as be 2 sho	plet						24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
E P	cate h	Completed						performe	ed? death ☐No 1 ☐Y	? 1//
V ILC	ector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only one)		
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ding C	th. : Afte e fune	ition	1 V Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day, Year) tion	Injury	Worl	(?¯` Yes 2 ∐No	200.000.000.000	injury coodinad	
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To the	vithin Fo the	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens			f. Date signed (Mo	onth, Day, Year)
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0			30. Name and address of person w			Print)	1			
1	B15		/		21 A	HANOVER	C PAKKU	JAY GK.	EEWISELI	T, MD 20770
	Sta	te	31. Date filed (Month, Day, Year)	2000 32. Registrar's Signa	ture					

State of	Maryland /	Department of	Health and	Mental	Hygiene	N

			1 - For State Registrar	State of Maryla		tificate of E			er Je () () ()	14/92
1.2	Dia	d	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medio		Gary W. Frantz						4, 2009	8:50 P M
1	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of Death	
			Goodwill Mennonite		- inch biob de A	Grantsvi If Under 1 Year	11e If Under 24 Hrs.	O Date of Righ	Garrett	-1 (Canada
N.	Funeral Director		5. Social Security Number 6. Sec. 18	7. Age (In y)	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 13	year) 9. Birth Con Mary	place (State or Foreign intry)
100	- St		Usuel Residence of Decedent	0)				Jan. 13	, 1940 Mar	/Iana
	how		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Ba-f-	ctor	MD Garrett		Grantsv	ille				1X Yes 2 □ No
	라 다 9r 28	Dire	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Cou	intry?
	e 23a	rai	19 Patton Lane		110	21536	0		USA 14. Race - Amer	ioon Indian
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other then "neturel", or Iteme 23a or 28a-f ehow event, the Madisal Examinat must be notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I □ Yes   2€ No	Specify:	Rican, etc.)	Black, White	
9	2 hou	ted	15. Decedent's Edu	cation	16a. Deced	ient's Usual Occupa	tion		16b. Kind of Business/l	ndustry
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	filed with Hygiene. other the	Con	Elementary/Secondary (0-12)		Owner	/Operator			Logging Co	mpany
Maryland	should be filed within nd Mental Hygiene. marked other then matic event, the Ma	Be	17. Father's Name (First, Middle, Last)  James Frantz				18. Mother's Name Laura Bel		•	
7	s 1 and 2 should I f Health and Menitem 27 ie marke other treumatic	2	19a. Informant's Name/Relationship (Ty	pe Print)	19b. Mailir				City or Town, State, Z	in Code)
Z	2 a = 0		Helen R. Frantz/Wi			atton Lan				,
re,	of Health item 27		20a. Method of Disposition		p. Place of Dispo	sition (Name of natory or other place	, C	ate	20c. Location - City or 1	Town, State
Ē	nit. Pages vartment of l ortant: If its injury or o		1 <b>X</b> Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State  Gr			1	27, 200	9 Grantsvil	lle, MD
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr		21. Signature of Fuperal Service License	imai		.O. Box 2			uneral Home MD 21536	es, P.A.
			23a. Part1. Enter be disease, or complishock, or heart failure. List only or	cations that caused the de ne cause on each line.	eath. Do not ent	er the mode of dying	, such as cardiac c	or respiratory arre	est,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	PROGRE  Due to (or as a cons  LEWY	equence of):	-	- 0/			
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Ö	endir sath. or: Af he fur	atic	1 Natural 5 Pending 2 Accident investigation		,,		es 2□No			
Division	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	spitel ours a neral filled		29a, Certifier 1 Certifying Phys	sicien: To the best of my l	cnowledge deatl	occurred at the tim	e date and place.	and due to the ca	ause(s) and manner as	stated
	ne Ho. n 24 h ne Fur	Medical	(Check only 2 Medical Examinate)	ner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my op	inion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	'~	)	29c. License			9d. Date signed (Month	n, Day, Year)
			KOL B	ndl	/	100.	34231		April 24,	2009
		6	30. Name and address of person who co			,				
211			Robin Bissell, 124			sville, MI	21536			
13	Sta	ite	31. Date filed (Month Property 0.2	000 32. Registrar's Sig	gnature	1.41				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 21,2009 0745 April Goldman Fred J. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8770571952 Wash., DC 1 X M 2 □ F 56 Months Days Hours 213-56-7093 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Montgomery Silver Spring 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20904 1106 Rosemere Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married White 1 ☐Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heating and College (1-4or 5+) Elementary/Secondary (0-12) Airconditioning Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claire Pomerantz Maxwell George Goldman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Rosemere Ave. Silver Spring, Md 20904 Mary Ellen Cain/Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crem. 4/23/2009 Beltsville,Md 4 ☐ Donation 5 ☐ Other (Specify) neral Service PHINTED ADMERINALDI FUNERAL SERVICE, P.A. \$241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 days Immediate Cause (Final Perforated Sigmoid Diverticulitis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Dav Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

Physician /Medical Examiner

**Physician** 

**Examiner** 

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f sl

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Wedlest Everning.

Baltimore, Maryland 21215-0036

Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be

Division of Vital Records,

4-21-2009

death with

Director

Funeral

ò

Completed

Be

2

/Medical

been signed by the attending physician and should be detached for use as the burial-transit certificate has I rector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Examiner Physician/Medical Completed by Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 ∐No 9 Unknown

1 □Yes

1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1X Yes 2 □ No 27. Manner of Death

1 🔼 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

Hospital: 1 
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28c. Injury at Work? 28d, Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifi

29c. License number D20772

29d. Date signed (Month, Day, Year) April 21,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MD Ira Tannebaum

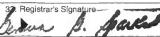
1500 Forest Glen Rd. Silver Spring, Md 20910

State Registrar

Medical

31. Date filed (Month, Day, Year)

5 ☐ Pending investigation



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** clling 9 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 194 www Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 19 Social Security Number **Funeral** M 2□F Min. Hours Months Days 75 1933 Director 214 30 5371 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show or other traumatic event, the Medical Examiner must be natified at 1 ☐ Yes 2 No Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with "natural", or items 23a or 4833 Roundhill Road 21043 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰6s 2 □ No If Yes, Give Year or Dates: 1954-55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 73. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mediconte. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Manager Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris William Gill Sr. Helen Spurrier ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah June Gill/Wife 4833 Roundhill Road Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 4-24-2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee Sherry (offino 4112 Old Columbia Pike Ellicott City, MD 21043 m01044 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** len /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏ Yes 2 □ No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signati 29d. Date signed (Month, Day, Year) 841 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) Ce 21044 15 Our 40 00 31. Date filed (Month, Day, Ye APR 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State	riease	State of Ma		d / Dep	artment of h	lealth and		/giene	009	14795
igh.	Physici	an	and the same	e (First, Middle, Las	(Del			Timeate of	Nealli	2. Date of D	Reg. No.	2 Year C	3. Time of Death  3 4 AM
	/Medi Examir	cal		n anda If not institution, give			Home	4b. City, Town, o	or Location of De	ath Md		County of Death	1
	Funeral Director		5. Social Security N	lumber 6. S			ast birthday Yrs.		If Under 24 H Hours Mi			13 9. Birth	nplace (State or Foreign intry)
	D		Usual Residence o 10a. State	f Decedent 10b. County		10c. City	, Town or L	ocation		3.11- 2	and the		10d. tnside City Limits
	r 28a-f el	Director	MD 10e. Street and Nu	Montgome	ry	Roc	kvi11	e 10f. Zip Code			10g. Citi	zen of What Cou	1X Yes 2 No untry?
	eath with	erai D		omac Vall	ey Road	Ever in II	S 13	20850	dispanie Origin?	(Specify Ves or N	,	ed Stat	
980	ours after de ral', or item Exeminer	by Fund	<ul><li>11. Marital Status</li><li>1 ∑Never Marr</li><li>3 ☐ Widowed</li></ul>	ried 2 Married 4 Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		3. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Specify:	erto Rican, etc.)	0-	Black, White	, etc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-1 show or other traumatic event, the Madical Examinar must be natified at	Completed by Funeral	(Spec	15. Decedent's Ecify only highest gra	lucation de completed) College (1-4or 5	5+)	(Give life.	edent's Usual Occup to kind of work done DO NOT use retire maker	during most of w	vorking		nd of Business/li Home	ndustry
Maryland 2	should be filed with and Mental Hygiene s marked other than numatic event, than	To Be Co		(First, Middle, Last) Goelet Jr						ame (First, Middle Monroe	e, Maiden	Sumame)	
Man	and 2 sho saith and I n 27 is me			ame/Relationship (7 MIller /	Гурв, Print) Sister			ing Address (Street Tesuque					
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any njury or other tre once.		20a. Method of Dis 1 Burial 2	position	Removal from State	C	emetery, cre	osition (Name of matory or other pla 1 Cremato		Date 4-2990		cation - City or T	
Balti	permit. Pages Deportment of Important: If it any njury or c		21. Signature of Fr	uneral Service Licen	P R	0		2. Name and Addre					
),	Physician /Medical Examiner pure legister phase	Examiner	shock, or hea tmmediate Cause disease or condition disease or condition resulting in death)  Sequentiatly list con if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	(Final on on of the conditions, on of the conditions, on of the conditions of the co	a. Due to (or as  c. Due to (or as  Due to (or as  Due to (or as	a consequence of the consequence	tas uence of): ) — ( uence of): +e2	e Des affect of Insi	nent I've	zchiz 18	opt	ven	Approximate Interval Between Onset and Death
P.O. Box 68760	The law requires thet the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 [ 9 Unknown	months?	d	2 Fetal	death 3	□Ectopic pregnanc	y		2	23d. Date of delin Month	very Day Year
	quires the n signed uld be dei		_		ontributing to death b	ut not rest	ulting in the u	underlying cause gr	ven in Part I.			J	the cause of death?
of Vital Records,		Completed by	· a	neumo nore	<i>iia</i>			· · · · · · · · · · · · · · · · · · ·			s an opsy ormed? 22 No	24b. Were aut prior to o death? 1 \( \subseteq \text{Yes}	topsy findings available completion of cause of
Vita	cian: ertific actor,	Be	25. Was case reference examiner?		Hospital:	-t 0 🗆	ER/Outpatie	ot ot ot	oc V	eath Check only			
	anding Physicath. or: After this confined funeral directions	ation: To	27. Manner of Deat  1 Matural 2 Accident	•	28a. Date of Inju (Month, Day	rv	28b. Time o Injury	of 28c. Inju- Wo	ry at	9 Home 5 ☐ Res 28d. Describe			ny)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3  Suicide 4  Homicide	6 Could not be determined	28e. Ptace of Injubuilding, etc	ury - At ho c. <i>(Specif</i> y	me, farm, st	reet, factory, office			(Street an own, State		ral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	examinal	wledge, dea ion and/or in	th occurred at the tinvestigation, in my	me, date and pla opinion, death oc	ice, and due to the curred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	TA TA ME	Σ	29b. Signature and	title of certifier	turn	CR.	np.	29c. Licens	se number 3971			e signed (Month	o 2009
			30. Name and addr	ress of person or	completed cause of d	eath (Item	23a) (Type	Print) Ma	lecula	VD/A	300	cuille	Md,
	Sta Registr	10	31. Date filed (Mon		2. Registra	ar's Signa	far	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 1 - For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 15:36 Vonal 2009 Haney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Medical Baltimore None otMaryland 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours 1 X M 2 □ F 7/24/1926 N.C. 245-24-8960 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machael Examiner must be notified at once. 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 No **Funeral Director** MD Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 USA 4036 Arjay Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 1943—
If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ Specify: 3 Widowed 4 Divorced 1946 Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Senior Vice President Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daisy Haney Everett McCall ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrice A. Stark / Daughter 4036 Arjay Circle, Ellicott City, MD 21042 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2 Cremation 3 ☐ Romoval from State 1 🔀 Burial DOMer (Specify) Parklawn Cemetery 4/27/2009 Rockville, MD 4 ☐ Donation Funeral Se vice Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Complications disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 days Fall EXPERITOR APPROPRIATE MEDICAL EXPURITOR Se menties list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical signed by the attending the detached for use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a. Was an autopsy certificate 1 □Yes 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To nours after death.

neral Director: After this
filled in by the funeral di this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Fall from Standing 1 ☐ Yes 119/2009 2 Accident 6 □ Could not be 3 Suicide 281. Location (Street and Number Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

1241

State Registrar 29b. Signature and title of certifie.

eted dause of death (Item 23a) (Type, Print)

ZZ

29c. License number

29d. Date signed (Month, Day, Year)

Street Baltimore MD 21201

State Registrar

Dr. Beverty Calkins, 31. Date filed (Month, Day, Year) MAY - 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Memorial Avenue, Cumberland, MD 32. Registrar's Signature

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			For State Registrar	State of Maryla		artmen e <i>rtificat</i>			nd Me		giene Reg. No.	2009	3	14798
	Physicia		1. Decedent's Name (First, Middle, Last)  Jean Cook Ja	acobs						Date of Dea Month pril 2	Day	009 Yea		8:13 P.M
	/Medic Examin		4a. Facility Name (If not institution, give s Suburban Hosp	treet and number)			Town, or L	ocation of		.pr.r. 2	4c. C	ounty of De	ath	
	Funeral Director		5. Social Security Number 6. Sex		yrs, last birthday 90 Yrs.	/) If Under Months		If Under 24 Hours	4 Hrs. 8. Min. M	Date of Birtl (Month, Day (arch 6	h Year) 5, 19	(	Country)	e (State or Foreign nsylvania
ore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventure result to notified an once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Montgot  10e. Street and Number  4701 Willard Avenue  11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  15. Decedent's Educ  (Specify only highest grade  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Max Tennen  19a. Informant's Name/Relationship (Ty, Paula J. Himowitz  20a. Method of Disposition  1 Burial 2 Cremation 3 R	mery  e, # 1110  12. Was Decedent Ever in Armed Forces? 1	16a. Dec (Giv.) Iffe. Te	hase  10f. Zip 2 . Was Decedif Yes, spector of Yes the dent's Usuary of Yes acher  lling Address Mead cosition (Nare	dent of His ifty Cuban  Monal Occupat k done du ke ratired)  (Street ar  OW SW 6  The of ther place,	Specify:  Specify:  18. Mother  Evand Number  eet Re	of working 's Name (F a Ber or Rural F oad, Date	First, Middle, ger Route Number	16b. Kind Pub Maiden S er, City or 7111e	Town, State	A.  nerican iite, etc. Wh  ss/Indus:	ite try 1s  ode) d 21208 , State
Baltimore,	permit. Page Department Important: II any injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	: Ulimyer#5	564	9an 2an 1170 R	ockvi	sofedbo ille	erg M Pike,	emoair Rockv	cl Ch ville	apels	, In	Virginia ic. id 20852
18:13 PM 8760, ED	Physician and physician and Examíner purial-transit stre purial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Stenos: sequence of): sequence of):		e or dyring	, such as c	arurac or r	езрігаюту ат	irest,		In	oproximate terval Between pset and Death INKNOWN
121/09 P.O. Box 68	ath ceri ttending or use a	Physician/Medi	in the past 12 months?  1 □ Yes 2 N No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 of death 5	B□Ectopic p B□Other (sp	pecify)					3d. Date of o	Da	
$\forall$ $\forall$ ecords, I	w requires that the designed by the should be detached	Completed by F	Part II. Other significant conditions con Pulmonary Atria			underlying o	ause giver	n in Part I.	_		Yes 202	¶No 3□	Probab	cause of death?
EAN ital Re	Physician: The law this certificate has b ral director, page 2 sl		25. Was case referred to medical					26. Place	of Death (6	autor perfo 1 □ Yes Check only o	rmed? 2 □ No	death	to comp ? es 2	y findings available letion of cause of
1 P	ling After Tune	Certification: To Be	examiner?  1 Yes 2 No H  27. Manner of Death  1 N Natural 5 Pending investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day, Yea	28b. Time		Other 28c. Injury Work?	r: 4 🗆 Nur	rsing Home	5 ☐ Resid. Describe I	dence 6	<del></del>	pecify)	
JA LOBS Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - A building, etc. (Sp. sician: To the best of my	knowledge, dea	ath occurred	at the tim	e, date and	d place, an	City or Tov	vn, State) cause(s)	and manne	as stat	Route Number,
•	To the Hoo within 24 h	Medical	(Check only one)  2□ Medical Examination  29b. Signature and title of centifier  30. Name and address of person who co	ner: On the basis of exar and manner stated.  — MD	(Itam 23a) (Tune	29	D0060	number			29d. Date	e signed (Mo	onth, Da	
	Sta Registr		Eric J. Park M.  31. Date filed (Month, Day, Year)		ld Geor	getow	n Roa	id, Be	ethes	da, Ma	ryla	nd 208	314	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nancy Lee Janes 5 м /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov. 27, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Year) 1 □ M 2 🔀 F 217-32-6727 71 1937 Nov. Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show traumatic event, if a livelical Examiner must be notified at 1XYes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 West Baltimore Street 21740 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Be Completed by If Yes, Give Year or Dates: Specify: white 3 ☐ Widowed 4 ☐ Divorced Separated
15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) cook - waitress food service h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any liury or other traumatic event other. 17. Father's Name (First, Middle, Last) Guy Newton Beall Viola Nunamaker ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Richardson - daughter 20 Manor Dr., #103, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Hagerstown Crematory 4/28/09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME XOU! 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bendamonal **Physician** memmano /Medical Due to (or as a consequence of): Examiner ougant ve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Coopelogoft Due to (or as a consequence of) Box 68760. Physician/Medical emi attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 14 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by n 24 hours after of e Funeral Direc determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East antietam St. (134-1 MO 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 20, 2009 P. Kopan April 11:14 Jeannette 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 X F 89 1919 577-16-2625 Aug. 12, Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1XYes 2 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 7420 Westlake Terrace, Apt. 1403 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Navy If Yes, Give Year or Dates: WW 2 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 📉 No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Accounting Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca Levy Nissim Penso 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 5429 30th Place, N.W., Washington, D.C. 20015 Edward Angel - Nephew 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Falls Church, Virginia King David Mem. Gdns 4/24/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Balizanskys Goldberg Memorial Chapels, Inc. Sonald C. 20852 1170 Rockville Pike, Rockville, Maryland 564 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pleural Effusion with Complications disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 2 🗆 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊈Yes 2 No 27. Manner of Death

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f shov

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any inJury or other traumatic event, in "Modical Examine: must be notified at any inJury or other traumatic event, in "Modical Examine: must be notified."

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed attending physician and for use as the burial-trai Box 68760, P.0. the signed by t d be detach Division of Vital Records, peen cate has t , page 2 s Physician: The

certificate |

this After this

h 24 hours are: ......he Funeral Director: Af

To the I within 2.

8

Hospital or Attending

director,

Examine Physician/Medical \$ Completed Be ို Certification:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only one)

28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and fitle of certifier

29c. License number D65312

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 21/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Subramanian Siva 3800 Reservoir RoadN. W., Washington, D. C. 20007-2113

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 23

5 ☐ Pending

investigation 6 Could not be determined



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Geo	orge Nicholas		acon S	tate of	Maryland	/ Depar	tment of ificate of	Health an Death	d Menta	al Hygie		g. No.	20	09 1480
	Physicia		Registrar 1. Decedent's Name (First, Mic	dle,Last)							ate of Death		Year	3. Time of Death
Me	dical Exami	THU .	George N. Ki		1					Ar	oril 28, 20	009		1100 hrs
1			4a. Facility Name (if not institu	ion, give str	eet and number	')		4b. City, Town, or New Carrol		Death			inty of Deatl	
			5701 85th Avenue	1	12.6	/le ure lee	4 histhday)	If Under 1 Yea		24Hrs 8.	Date of Birt		777) 9. Bii	rthplace (State or
	Funeral Director		5. Social Security Number 217-70-6404	6. Sex		ge (In yrs. las	Yrs	Months Day		100	July 5		Forei	gn Cheverly, MD
			Usual Residence of Decedent	I A M	ZF			<u>.   </u>		1				
	any	İ	10a. State 10b. Coun	у		10c. City, T	own or Locat	ion						10d. Inside City Limits 1 X Yes 2 No
-	and show nce.	5	Maryland How	ırd		]	Laurel					211	(11)	
3	Maryla 28a-f d at o	Director	10e. Street and Number					10f. Zip Code			10		of What Cou	anti y ?
413	vith the Maryland s 23a or 28a-f show a e notified at once.		10647 Whiter					1	)723	i=0 / Cresif	. Yes or No	USA	Pace - Ame	rican Indian, Black,
	th with	unera	11. Marital Status 1 X Never Married 2	Married 12	. Was Deceder Armed Forces			as Decedent of H es, specify Cuba					White, etc.	
	er dea	Fur		)ivorced If Y		2 X No	1	Yes 2 X N	o specify:			Spe	<sub>cify:</sub> Wh	ite
	ors after	b	15. Decedent's Education (S	or	Dates:	ompleted)	16a, Deceder	nt's Usual Occupa	ation (Give I	kind of work	done	16b. Kind	of Business	/Industry
	72 hou 1 "nat	etec	Elementary/Secondary (0-1	2)	College (1-4 o	r 5+)	•	nost of working lif						4.4
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	12				So	le Propi					nstru	ction
	5-0 iled w Hygie I othe	ပ္ပ	17. Father's Name (First, Mide							's Name (Fir aret		Maiden Sun	name)	
	121 d be f feutal narked	Be c	George M. Ki				19h Mailin	g Address (Stre				nber, City o	r Town, Sta	te, Zip Code)
	MD 2 nd 2 shoul alth and N m 27 is m	7	Carol K. Han				1	6 Via Ro						
	and 2 lealth tem 2		20a. Method of Disposition				lace of Dispo	sition (Name of c			ate			or Town, State
	DOF ages 1 tr of F		1 Burial 2 X Crema		Removal from		rematory or o	an Cremato	ory	5/1/	2009	Alex	kandri	ia, Virginia
	Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	4 Donation 5 Other 21. Signature of Funeral Serv	ce Licensee				Name and Addre				473	9 Bal	timore Ave.
	Ba Per Julian		( ) andette	-95	asch	Lanni	na Ga	sch's F	uneral	L Home	, P.A	. Hya	ttsvi	11e, MD 2078
	Physician		23a, Part I. Enter the disease failure. List only one car	co on each	line					ardiac or re	spiratory arr	est, shock,	or neart	Approximate Interval Between Onset and Death
	/Medical caminer	9	Immediate Cause (Final dise	se a. D	iphenh			oxicatio	on					Death
н			or condition resulting in death	Due	e to (or as a cor	nsequence of	):							
		ē	Sequentially list conditions, if any, leading to immediate		e to (or as a co	nsequence of	):							
		Examiner	Disease or injury that initiate	d C.	e to (or as a co	nsequence of	ñ:							
	ansit		events resulting in death) La	d.		·								
	Box 68760, e death certificate be executed the attending physician and of for use as the burial - transit	edical	Xunpended		MENDED 2	3a,27,	28a-i,	perME, {	g891 5	0/8/09	11			
	'60, cate be physic he bur	ĕ	IF FEMALE:		23c. If yes, out	come of pregi							ate of deliv	very Day Year
	687 certific	ian/M	23b. Was decedent pregnant past 12 months?	n the	1 Live birth	at time of de		etal death Other (Specify)	3Ectop	ic pregnancy	у	I M	onth	Day Teal
	Box 6876( he death certificate the attending phy-	ysici	1 Yes 2 No 9	Unknown	9 Unknowr			other (Specify)					_	
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	Vit; hysich this o	🖺	examiner?	Hos		atient 2	ER/Outpatie		Other <sub>4</sub>		Home 5_		e 6 V O	ther: Scene
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	SIOF Mitend death ctor:	jặ; Į	2 Accident	ending nvestigation	Fd 4/	28/09	Fd 10	:00 am reet, factory, offic		_   1	nedica 8f. Location		Number or	Rural Route Number, Cit 5th Ave
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	.g. 8 g. c.		4 Homicide 29a. Certifier 1 Certifyir	n Physician	To the heet o	f my knowled	ne death oc	curred at the time	date and p	lace, and di	ue to the ca	use(s) and	manner as	stated.
	Fo the Hos within 24 h Fo the Fun completely	ledical	(Check only one) 2 Medical	Examiner:C	n the basis of	examination a	and/or investig	gation, in my opir	nion, death o	occurred at t	he time, dat	e and place	e, and due t	o the cause(s)
	- 14 E	≥	29b. Signature and title of ce		no manner stat			29c. Lic	ense numbe	er				(Month, Day, Year)
	/		hig hi	1 2	2			0.	C.M.E.			April	29, 2009 	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6,2009 Ira Wayne Kittre11 7:20 DRI 4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days Hours Min 1 X M 2 □ F 219-78-7642 North Carolina Ju**ne** 19, 1959 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b Counts 10c City Town or Location Md. Prince Georges Hyattsville 1X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20784 U. S. A. 7000 Barton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Elevator Operator Federal Building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Lillian Lomax 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Ann Townes (Sister) 7000 Barton Road Hyattsville, Md. 20784 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State 04/25/2009 Beltsville, Md. Chesapeake Crematory 4 □ Donation 5 □ Øther (Specify) 22. Name and Address of Facility W. H. Bacon Funeral Home, 21 Signate of Funeral Service 3447 14th Street, N. W. Washington, DC 20010 200 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death 54290 END Renal disease or condition resulting in death) Due to (or as a consequence of) Artery disease ramora Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Hypert ension Due to (or as a consequence of) neumonial IF FEMALE yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 🔀 No 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

Physician: The law requires that the death certificate be executed and burial-trar Box 68760. the as use for P.O. | signed be deta Division of Vital Records, cate has been signated by certificate director. this After 1 Hospital or Attending

death.

24 hours after deat Funeral Director:

within 2 the

Physician/Medical Completed Be Medical Certification: To funeral completely filled in by the

Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

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items 23a

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If item 27 or other tra

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Pages 1 and 2 should

Health a

5 Department of Important: If it any Injury or c

**Physician** 

Examiner

/Medical

Itimore, Maryland 21215-0036

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

25. Was case referred to medical

1 Natural
2 Accident 5 Pending investigation

6 Could not be determined 3 Suicide 4 Homicide

29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier PIIBLONG. 29c. License number D0059981 29d. Date signed (Month, Day, Year) 411712009

MO 20 769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andella, MD 12200

GLEND DALE ANNAPOLIS ROAD SUITE 229

State Registrar 31. Date filed (Month, Day, Year) 2009

32. Registrar's Signature

For State Registrar

Paul

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

Lester

Long

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

April 26,

2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Be Van LE 02 200 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death County of Death Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Y) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Year) Months Days Hours Min. 1**⊠** M 2□ F 66 1942 Vietnam 213-98-7527 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County Maryland Washington Hagerstown 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 West Wilson Boulevard 21740 Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 Married Specify: Vietnamese 1 ☐ Yes 2 🖾 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Independent contractor ieweler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Van Thanh Le Kiem Thi Huy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nguyet Thi Nguyen - wife 510 West Wilson Blvd., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 208<u>4</u> April. Rose Hill Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 East Wilson Blvd., Hagerstown, Maryland 21740 Kalenty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: yes, outcome of premancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ™ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No Was an autopsy performed

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

23a

items 2

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'natural"

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h and Mental Hygier 7 Is marked other th

Department of Health ar Important: If item 27 Is any Injury or other trau

with ō

72 hours after

9

Pages 1 and 2 should

permit.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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traumatic event, the Medical Evand and cust by notified at

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar signed by the a s been si should b has

Box 68760,

P.O.

Records,

Division of Vital

page 2 certificate this certific al director, After thi ithin 24 hours after death.

the Funeral Director: A pmpletely filled in by the fu death.

Examiner

Physician/Medical \$ Completed Be Certification: To

25. Was case referred to medical examiner?

1 Tes

27. Manne Death

1 atural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

2 No

5 Pending investigation

Could not be

determined

3H-5

To the lawithin 2 To the I

State Registrar

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause

1 Inpatient

28a. Date of Injury/ (Month, Day, Year)

1 □Yes 2 No of Death Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

egistrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

Csilla Margaret Luckett

1- For State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2009 14805

Physici	an/	Decedent's Name (First, Middle,I	_ast)					2. Date of			3. Time of Death
edical Exam		Csilla	Luckett					Month April 22	Day 2, 2009	Year	0100 hrs
		4a. Facility Name (if not institution,				ity, Town, or L		Death	4c. Cou	inty of Death	
		Sputh Bound I 495 Just	South of Ritchie M	larlbor⊳ <del>R</del> ॄ	Road Ca	apitol Heigh	nts		Princ	e George'	S
Funeral		Social Security Number     6	. Sex 7. Age	(In yrs. last b	irthday) If	Under 1 Year	If Under 2	4Hrs. 8. Date o	f Birth (MM/DD/Y		
Director		579-56-8783	M 2XF	64	Yrs. M	onths Days	Hours	May May	19 1944	Foreigr Cou	ntry)Hungary
		Usual Residence of Decedent									7
any		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
d d		VA		Ale	xandria						1 X Yes 2 No
rylan a-f sl	cto	10e. Street and Number		1110		. Zip Code			10g. Citizen d	of What Coun	try?
e Ma or 28	Director		C+				1 /		,		•
death with the Maryland or items 23a or 28a-f show any must be notified at once.		420 N. Alfred		E1- IA D	40 1Waa Da	223		2 / C===i6: V== 0		USA	an Indian, Black,
th wi	Funeral	11. Marital Status  1 Never Married 2 Marr	12. Was Decedent Armed Forces?	Everin U.S.				? ( Specify Yes o uerto Rican, etc.		White, etc.	all Ilidiali, black,
r dea	Fu		1 Yes 2	X No					0	Wh	ite
s afte	by	3 Widowed 4 Divor	or Dates:	-1-1-1	a. Decedent's U	2X No		d of work done	Spec	of Business/Ir	
hour matu Exan	pa	15. Decedent's Education (Specif			during most o				Tob. Kind (	Ji business/ii	ldustry
36 in 72 han '	plet	Elementary/Secondary (0-12)	College (1-4 or 5	)+)	Шов	ah av			17.4	ucatio	
21215-0036 unld be filed within 7 Mental Hygiene. marked other than	Completed	17. Father's Name (First, Middle, L			Tea	cher	9 Matharla I	Name /First Mide	dle, Maiden Surn		11
filed Hygel						1					
d be fenta	o Be	Charles 19a. Informant's Name/Relationship			Ob Mailing Ade	trans (Ctrant		_	Number, City or		Zin Codo)
D 2 shoul and A 7 is n	ř	Edward Luckett	, ,, ,	14	-	,			-		
e, MD 21215-0036  I and 2 should be filted within 72 hours after death with the Maryland Hajane And Hayland Hajene it is marked other than "natural", or items 23a or 28a-f she it raumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition	Spouse	20h Place	e of Disposition			Date	dria, V	tion - City or	
or He If it her t		1 X Burial 2 Cremation	3 Removal from Sta		atory or other p		ictory,	50.0	2001 2000	and only on	rom, otato
mor Pages   nent of   ant: If or other		4 Donation 5 Other Spec			Mary's	Cemete	ry 4	4/30/200	9 Alex	andria	, VA
Baltimore, MD 21215-0036  Permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene.  Important: If item 77 is marked other than "natural"; in juny or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service Li	censee		22. Name	and Address	of Facility	Everly	Wheatle	y Fune	ral Home
<b>a</b> 52 5 5	R 8	Som C	moi		1500	W Brad	ddock	Rd Alex	andria,	VA 22	302
Physician		23a. Part I. Enter the disease, or co failure. List only one cause or		the death. Do	not enter the m	ode of dying, s	such as card	diac or respirator	y arrest, shock, o	or heart	Approximate Interval Between Onset and
/Medical caminer		Immediate Cause (Final disease	a Multiple Injuries								Death
tailillei		or condition resulting in death)	Due to (or as a conse	equence of):							
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	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):							
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30, te be ysici	ed	IF FEMALE:	23c. If yes, outcom			)—IZ—UJ	V C		22d Ds	ate of delivery	<u> </u>
68760, ertificate bu ding physic	1	23b. Was decedent pregnant in the	1 Live hirth	-	o Fetal d	eath 3	Ectopic p	regnancy	Mor		Day Year
x 6 h cer tendii		past 12 months?	4 Pregnant at	time of death	5 Other	(Specify)					
Box e death the atter ed for u	Physi	1 Yes 2 No 9 V Unkn	own 9 Unknown								
cords, P.O. Boy law requires that the death has been signed by the attu 2 should be detached for 1	<u>-</u>	Part II. Other significant conditio	ns contributing to death	n but not resul	ting in the unde	lying cause gi	ven in Part				the cause of death?
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of Vital Records, P.O. Box 68760, ling Physician: The law requires that the death certificate be execut After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran	မ	1 Yes 2 No 27. Manner of Death	i iiipatie		Outpatient 3	DOA	y at Work?	Nursing Home	ribe how injury o		. Scelle
n o ding Afte funer		1 Natural	28a. Date of Inju (Month, Day Y Apr 22, 2009	ear) 28	b. Time of Injury )30 hrs		yatwork? es 2 ✔ N	Passent			or vehicle collisior
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that is after death.  In all Director: After this certificate has been signed be led in by the funeral director, page 2 should be detax	rtification:	2 Accident Investi	gation						(0)		and Double 11 in the
Divis tal or A rs after al Direc	tii	3 Suicide 6 Could				ctory, office bu	uilding, etc.	or To	wn, State)		ral Route Number, City
		determ	ined (Specify) Inte	arototo/Evn	rocc			IISR 1-495	S of Ritchie M	ariboro Rd	Capitol Heights, MD

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

JK

Medical Certi

4

Homicide 29a. Certifier (Check only one)

29b. Signature and title of certifier

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year) 32. Registrant Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

OCME

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 22, 2009

(Specify) Interstate/Express

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar\_AMFND#14perINF4/23/09,EMW,McCo Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** Alfredo Cesar Mistral 1405 M 2009 April 16, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 577-58-0912 Months 1 X M 2 □ F 80 Director August 18, 1928 Cuba Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, It a Medical Examiner must be notified at Director Montgomery Silver Spring 1 TYes 2 N No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 USA 1135 University Blvd. West, Apt. 107 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. White 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2XX Married 1XIYes 2□No Specify: Cuban Specify: Hispanic þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, It a Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Immigration Officer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isabel Gainza Alfredo Hernandez ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1135 University Blvd. West, Apt. 107, Silver Spring, MD 20902 Leticia Mistral / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cate of Heaven Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State April 21, 2009 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Et a company Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2. 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 ☐ No 3 ☐ Probably 4X Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an performed? ves 2.00No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2√ ER/Outpatient 3 ☐ DOA 1 Tes 2 No 2 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed Box 68760. attending physician P.O. the ģ Records, peen has of Vital this Division

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death 1

within 72 hours after

Maryland 21215-0036

Baltimore,

the as nse for detached page 2

certificate director, After 1 Hospital or Attending To the Hospital or Attendi within 24 hours after death. NTo the Funeral Director; A death completely filled in by the

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State Registrar

Medical

31. Date filed (Month; Day, Year) 23 APR

4 Homicide

(Check only one)

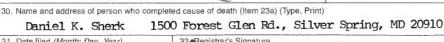
29b. Signature and title of certifier

Daniel K. Sherk

29a, Certifier



and manner stated.



32 Registrar's Signatu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D67355

29d. Date signed (Month, Day, Year)

April 16, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#23aI+II, 29aperMD4-29-09, EMW, Westificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 **Physician** Leatha P. Marsh 17, 10:50 P April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2609 Iverson Street Prince Georges Temple Hills, 8. Date of Birth (Month, Day, Year) (Supplemental St., 1917 North Carolina Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1□ M 2 1 1 F Months Days Hours Min. 92 Director 240-36-7035 Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the integral Even it at must be notified at 1 to Yes 2 No Directo Temple Hills Maryland | Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2609 Iverson Street 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ∐Yes 2 1 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify. Specify: Black 3 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5th. College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumant. Housewife none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Parker Cora Deese ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Lewis Marsh - son 2609 Iverson Street, Temple Hills Md. 20748 20b. Place of Disposition (Name of Ukn cemetery, crematory or other place) DateUkn 20a. Method of Disposition Ukn 20c. Location - City or Town, Stat DC 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3831 Georgia Ave. N. W. MD278 Latney's Funeral Home Washington, D. C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal insufficiency To Thrive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. CHF-Concestive Heart Failure Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and is the burial-tran-Cardiomegaly Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ <u>Dementia</u> Decubitus ulcer 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed Adult failure to thrive **Emphysema** 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has , page 2 s autopsy certificate perforn 2 1 No 1 □ Yes 2 🗆 No Diabetes
25. Was case referred to medical examiner? 1 □ Yes director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☐ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending ours after death. neral Director: ⊁ filled in by the fo 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funeral D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical etely (Check only onel within 2 To the

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifies

31. Date filed (Month, Day, Year)

2-100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

29c. License number

H(a) a(a)

29d. Date signed (Month, Day, Year,

			1 - State of Marylan		epartment of h Certificate of			ene 3. No. 2	3 14808
	Physicia	on	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Carol Lee Mason				April	25 2009	7:50 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death	1	4c. County of Dea	
• '	Eupoval		Julia Manor 5. Social Security Number 6. Sex 7. Age (In yrs.	last birth		erstown   If Under 24 Hrs.	8. Date of Birth	Wash 9. Bi	nington rthplace (State or Foreign
	Funeral Director		217-28-7069 <sup>1□ M 2</sup> XF 76	Υr	Months Davs	Hours Min.	8. Date of Birth (Month, Day, Nov. 9, 19	Yea <i>r) C</i>	ountry) Maryland
7	3		Usual Residence of Decedent						
, chica	show det	7		y, Town o	or Location				10d. Inside City Limits 1 🛣 es 2 □ No
N	28a-f	ect	Maryland Washington		Hagerstow 10f. Zip Code	n	10	g. Citizen of What C	
t dija	a or	Ö	10e. Street and Number 903 Queen Annes Court			1740	10	g. Citizen of What C	•
4	ms 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.	s.	13. Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14, Race - Am	
و م	or iter	Ē	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 🗗 No		If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Black, Whi	te, etc.
3	ral",c	d by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □Yes 2 💢 No	Specify:		Specify:	White
ה ה	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	ation during most of wor	king	6b. Kind of Business	s/Industry
7	than	g E	Elementary/Secondary (0-12) College (1-4or 5+)	'	Secret			Medio	221
ָם קור כ	Hygi Sther ent, ti	Be Co	17. Father's Name (First, Middle, Last)		pecter		ne (First, Middle, M.	-	Jai
<u> </u>	lental Hental Ked o	To B	Carroll Austin Gardner			Retta	Maude Ai	cmstrong	
naiyianu Z IZ I 3-0036 9 should be filed within 79 bours offer death with the Mandard	sind Nand Nand Nand Nand		19a. Informant's Name/Relationship (Type. Print)	19b. N	Mailing Address (Street	and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
, <b>M</b>	ealth n 27 i	J. 15	David Miley-Personal Rep.		80 Sugar Hi		ewport, Ti	N 37821	
ַב בַּב	Destinance ages I also associate mea within 72 froots are treath with the way had Destination of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it at Medical Exercitar must be notified at orde.	1	20a. Method of Disposition 14 Surial 2 □ Cremation 3 □ Removal from State	'lace of D emetery,	Disposition (Name of crematory or other place	ce)	Date 2	Oc. Location - City of	r Town, State
	tmen tant: jury		4 □ Donation 5 □ Other (Specify) Gre	enla				Williams	ort, Maryland
Dal	Depar mpor any in		21. Signature of Fune al Service Licensee		OSBOTTIE AFT				01505
			23a. Part 1. Enter the dise se, or complications that caused the death		425 S. Con				, MD 21795 Approximate
			shock, or heart failure. List only one cause on each line.		_			, ,	Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a		Renal	1) 152	AST		
	xaminer		n h	derice of	Men. t	J<"			
Ę		je	if any, leading to immediate	uence of)	):				
cuter	nd transi	Examiner	Cause (Disease or injury that initiated events	ny.	aidim	1			
icate be executed	cian a	Ě	resulting in death) Last Due to (or as a consequence of the consequenc	uence/of)	i:				
Cate	physician and sthe burial-transit	dical	d						
Certif	igned by the attending post of the control of the c		IF FEMALE: 23c. If yes, outcome of pregna	ancv				23d. Date of de	livory
death of	atter	ciar	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  25c. Yes, outcome 1   Live birth 2   Feta	l death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		Month	Day Year
9	by the	Physician/M	9 Unknown						
, o	gned e det	by P	Part II. Other significant conditions contributing to death but not resu	ulting in t	he underlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
	s been si						1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown
i we	as be	plei					24a. Was an autopsy		utopsy findings available completion of cause of
The The	cate h	Completed					perform	ed?   death?	
VILO	certifi ector,	Be	25. Was case referred to medical examiner?		Cut		th (Check only one,	)	
P A	r this	은	1  Yes 2	ER/Outp		4 Libersing H	lome 5 ☐ Resider	ce 6 Other (Sp.	ecify)
	th. After	tion	1  Natural 5  Pending (Month, Day, Year) 2  Accident investigation	Inji	ury Wor	k?  Yes 2 □No	Zou. Describe nov	Injury occurred	
Atten	r deat	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At ho	me, farm			28f. Location (Stre	eet and Number or F	Rural Route Number,
<u> </u>	s afte	Certification:	4 ☐ Homicide determined building, etc. '(Specif	<i>y)</i>			City or Town,	State)	
the Hospital or Attending Physician: The law requires that the death certif	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.						
To th	withir To th comp	Me	29b. Signature and title of certifier		29c. Licens		29	d. Date signed (Mon	th, Day, Year)
			Favil mulus		200	:0396		04/27	( 9
5r	1-2		30. Name and address of person who completed cause of death (Item	1 23a) (Ty	ype, Print) 112	, opal	C)	Ma 117	40
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Śigna	ture		A genst	2 V , /	• ( )	
ZHIV.	Registr	al'	APR 28 2009	1	A CONTRACTOR OF THE PARTY OF TH				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	State of Marylar	•	rtment of H tificate of L		, ,	0.000	
			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	uncate of L	Jeani	Re 2. Date of Death	g. No. 2 11 11 9	3. Time of Death
	Physicia		NELSON H	<b>Ξ</b>	MILLI	SON		Month	Day 2009	4:51 P M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death		4c. County of Death	
and fred				and Court		Freder			Frederi	
	Funeral Director		5. Social Security Number 6. Sex 1 № 1	7. Age (In yrs. 4.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG. 1,	Year) 9. Birtl Co. 1963 Mary	nplace (State or Foreign untry) yland
	pu "		Usual Residence of Decedent  10a, State 10b, County	100 0	ty, Town or Loc	ation				10d. Inside City Limits
	naryla F show	ō	Maryland Freder		Frede					1 ☐ Yes 2 🕅 No
	the N	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	3a or	a D	6913 Double Bra	and Court		2170	3			ates
	items 2	Funeral	TT Wanta Otatoo	2. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show Ma Jigol Examinar must be porfited at	δ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🙀 Divorced	1  Yes 2 No If Yes, Give Year or Dates:		□Yes 2∏No	Specify:			hite
<u>,</u>	n 72 h	Completed	15. Decedent's Educa (Specify only highest grade	completed)	i (Give I	ent's Usual Occupa kind of work done o OO NOT use retired	lurina most of work		6b. Kind of Business/I	ndustry
717	filed within 7 I Hygiene. other than "r ent, II	mo	Elementary/Secondary (0-12) 10th	College (1-4or 5+)		nstruction			Building	
9	al Hygi t other vent, II	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M.	aiden Surname)	
Maryland	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important; If Item 27 is marked other tray injury or other traumatic event, Inc.	2		Wayne Mill	ison		Phylis	Α.	Penne11	
<u>Mar</u>	12sh thand 7 is m traum		19a. Informant's Name/Relationship (Type	. 1					City or Town, State, Z	
<u>မ</u> ်	1 and Healt tem 2		Phylis A. Millison 20a. Method of Disposition	·		ition (Name of atory or other place		<del>*</del>	/ Emmltsbur Oc. Location - City or 7	g, MD 21727 Fown, State
aitimore,	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Red	movai irom State			i		·	
	mit. F sartm sortar / injur		21. Signature of Funeral Service Licensee		aurrer 22	Cremator  Name and Addres	y 104/21 ss of Facility Sta	./2009   F uffer Fu	rederick,M neral Home	laryland
מ	an James		Raymond ?	Peterson					erick, MD	21702
			23a. Part1. Enter the disease, or complication shock, or neart failure. List only one	ations that caused to dear	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
44	Physician		Immediate C e (Final disease or condition	Han	aina					Onset and Death MINUTES
	/Medical Examiner		resulting in death)	Due to (or as a consec	nce of):					•
	L. LO	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	juence of):				-	
	cuted nd ansit	Examiner	Cause (Disease or injury that initiated events							
Ď,	e exec ian an ırial-tr	Exa	resulting in death) Last	Due to (or as a consec	quence of):	,				
8/eU	icate be executed physician and the burial-transit	edical	d.							
ŏ ×	leath certific attending p for use as t		IF FEMALE:	c. If yes, outcome of pregn	anov					
Z D D	atten for us	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	al death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date of deli Month	very Day Year
j	the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		- Carlot (opedity)				
, L	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions contr	-	ulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ecords,	equire		Depression	7				1 ☐ Yes	s 2 No 3 Pro	obably 4 🗆 Unknown
e C	e law r has b	Completed						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u> </u>	icate icate	Con						perform 1 □ Yes 2	ed? death? No 1 ☐ Yes	2 XNo
Z Z	siciar certif rector	Be	25. Was case referred to medical examiner?  1 Yes 2 □ No	spital:	1==/0	Othe	7r.	h (Check only one		
5	J Phy er this eral di	7: To	1 Nes 2 No No 27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury Work	4 Li Nulsing He	ome 5 X Resider 28d. Describe hov	nce 6 Other (Spec	cify)
SION	arth. rr: Affa	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	Asci / 18 2009	Unknoz	_M 1 □\	? Yes 2.▼No	Subject	hanae	1 5elf
<u>2</u>	r Atte ter de irecto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		28f. Location (Street, City or Town,	eet and Number Ru State Brand	ral Route Number
ב	oital o urs afi ral Di			at ho	me.	<u>-</u> -		6413 001	Freder	rick: MD
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical		cian: To the best of my known: On the basis of examination and manner stated.						
	To th Vithin COMP.	Me	29b. Signature and title of certifier			29c. License			d. Date signed (Month	
			Man Kohre	AMD DA	1E	D3	7197	1	Ipril20	2009
	3		30. Name and address of person who com	preted cause of death (Iter	m 23a) (Type, F	Print) the	'i .L	- 1	1. 1.	, 2009 21701
		to	Han Kohver MD 31. Date filed (Month, Day, Year)	DM E 15	West	1-32	creet,	Freder	TICK, MI	0 61 101
	Stat Registra		APR 23 2	1019 Daneura	1 1.	back			,	

DHMH 17 Rev 1/2001

19-03448 Rebecca Beatric	~ E	Please Type or Prin						ible.	
Rebecca beathc		upe Martin State of Ma	ryland / Depar		of Health a of Death	nd Mental F		200	9 1181
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		neate c	Deaur		2. Date of Death	J. No. 200	3. Time of Death
Medical Exami		Rebecca Bernice Marti	n .					Dav Year	1045 hrs
53		4a. Facility Name (if not institution, give street an			4b. City, Town,	or Location of Deat		4c. County of Death	)
-		650 Foy Road			<del>Luke</del>	McHenry		Garrett	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Y		_		thplace (State or Foreign untry)
Director		486-09-0363 <sub>1 M 2</sub> X	F	93 <sub>Yr</sub>	Months D	ays Hours Mi	July ]	L5, 1915 Mi	ssouri
		Usual Residence of Decedent							
w an		10a. State 10b. County		own or Loca	ition				10d. Inside City Limits  1 Yes 2 X No
·f sho	호	MD Garrett	McHe	nry	1		Lie		
Mary r 28a	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	ntry?
ith the	믵	650 Foy Rd.  11. Marital Status 12. Was	Daniel Conic II C	T 42 14	2154	<b>Ł⊥</b> Hispanic Origin? ( \$		JSA	ises Indias Disale
ath w	uneral	1 Never Married 2 Married Arm	Decedent Ever in U.S. ed Forces?			pan, Mexican, Puerl		White, etc.	ican Indian, Black,
fler de	巴	3 X Widowed 4 Divorced If Yes, Giv	es 2 X No e Year	1	Yes 2 X	No specify:		Specify: Whi	.te
ours al	d b	15. Decedent's Education (Specify only highes	t grade completed)		nt's Usual Occu	pation (Give kind of		16b. Kind of Business/	Industry
5 72 ho	Completed	Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)			ife. DO NOT use re	tirea)		
203	티		1	Secre	etary			Clerical	
15-C	ပ္စု	17. Father's Name (First, Middle, Last)  Ernest Newton Jasper	Pouno				ne (First, Middle, M Orence Go	,	
12' Id be: Aental narke	o Be	19a. Informant's Name/Relationship (Type. Print	_	10h Mailir	og Address (Ct			per, City or Town, State	Zin Codo)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ě	Cristina Beitzel/Gran	,			McHenry			s, Zip Gode)
e, N and 3 and 3 fealth item 3		20a. Method of Disposition		I ace of Dispo	sition (Name of		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr.		1 Burial 2 X Cremation 3 Remo		ntry or o		ematory M	av 5, 20	09 Davidsv	ille, PA
iltin ait. P. artme ortan	-	4 Donation 5 Other Specify: 21. Signature of Fugeral Service Licensee	1 000					eral Homes	
Ba Perr Perr Dep Dep Injury	ļ	D. Lun Skim	and			275, Grai			110-110-110
Physician		23a. Part I. Enter the disease, or complications the failure. If stip you one cause on each line.	hat caused the death. [	o not enter	the mode of dyir	ng, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner			rosclrotic	cardi	ovascu1	ar diseas	se		Death
Xammer		or condition resulting in death)  Due to (or	as a consequence of):						
	늘	Sequentially list conditions, if any, leading to immediate b Due to (or	as a consequence of):						-
	ii.	cauce. Enter Underlying Cauce (Disease or injury that initiated	as a consequence or,						
ed sit	Examiner	events resulting in death) Last Due to (or	as a consequence of):						
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th cer trendi	icia	1 Yes 2 V No 9 Unknown	Pregnant at time of deat	h 5 C	other (Specify)				
Bo he dea	Physician/Med		Jnknown				OD- Didtel	pacco use contribute to	Ab
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	þ	Part II. Other significant conditions contribut  Malnutrition; foca	_	-	unceriying caus	e given in Part I.	1 Yes		bably 4 Unknown
duires, l	Completed	mainutifition; foca	г риеншопта	1			24a. Was a		utopsy findings available
Orc law re las be 2 shor	ple						autops perforr	y prior to	completion of cause of
Re( The	S.						1 <b>✓</b> Yes 2		es 2 No
ician:	Be	25. Was case referred to medical examiner?				Other: Nurs			
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nding th.	ē	1 X Natural 5 Pending	Date of Injury Month, Day,Year)		·	Yes 2 No		<b>,,</b>	
iSic	icat	2 Accident Investigation 28e.	Place of Injury - At hon	ne, farm, stre	eet, factory, offic	e building, etc.	28f. Location (St	treet and Number or Ri	ural Route Number, City
Div ital or ral Div	ertification:	Suicide Could not be	ecify)		•	•	or Town, St	ate)	
Hosp 24 hou Fune tely fi	ပြ	29a. Certifier 1 Certifying Physician: To the	e best of my knowledge	, death occu	urred at the time,	date and place, ar	nd due to the cause	(s) and manner as sta	ed.
Division of Vital Records To the Hospiral or Attending Physician: The law requirent the Land or Attending Physician: The law requiremental Director: After this certificate has been completely filled in by the funeral director, page 2 should	Medical	one) 2 Medical Examiner:On the b	asis of examination and ner stated.	l/or investiga	ation, in my opin	ion, death occurred	at the time, date a	nd place, and due to the	ne cause(s)
FSFS	ž	29b. Signature and title of certifier				ense number		29d. Date signed (Mo	nth, Day, Year)
		Allem Dravell, M	6		0.0	C.M.E.		April 30, 2009	
OCME		30. Name and address of person who completed			D	D-16	0.04004		
			Medical Examine			Baltimore, MI	21201		
St Regist	ate rar	<b>銀 4 7 4 7 1 1 9 </b>	2. Registrar's Signature	park	d				
	_	A and the	70						

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

**Physician** /Medical

Examiner

Director

Completed by Funeral

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

**Funeral** Director

For State	State of N	/laryland / [	Depa	ırtmer	nt of h	Health ar	nd M	lental Hygid	ene		
Registrar		, ,				Death			j. No. 2	nng	14811
Decedent's Name (First, Middl		0.55						2. Date of Death Month	Day	Year	3. Time of Death
Facility Name (If not institution	Arturio Eug		ď	4h City	. Town	or Location of I	Death	April	18 4c. Cou	2009 inty of Death	8:20 a <sup>M</sup>
Sanctuary at Hol				4D. Oity		rtonsvil			10. 000	Montg	omery
Social Security Number	6. Sex 7. A	Age (In yrs. last bi	rthday)	If Unde	r 1 Year	If Under 24		8. Date of Birth (Month, Day,	(e <i>ar</i> )		lace (State or Foreign
578-80-6023	1 🛣 M 2 🗆 F	52	Yrs.	WIOTHIS	Days	Flours	rvsii f.	August 09	,		ct of Columbi
ual Residence of Decedent a. State 10b. County	,	10c. City, Tow	n or Lo	cation						1	0d. Inside City Limits
						Hyattsvi	116				1 ☐ Yes 2 No
Maryland Prin e. Street and Number	ce George's			10f. Zi	p Code	nyattsvi	116	10:	g. Citizen	of What Cour	itry?
7009 Wells	Parkway					20782				U.S.	Α.
. Marital Status	12. Was Deceder Armed Forces		13. V	Vas Dece	edent of 1		n? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
1 Never Married 2 Mar	ried 1 ☐ Yes 2 ∑ If Yes, Give	No		i fes, spi I∐Yes			MEILO			ecify:	010.
3 Widowed 4 Divorced	Year or Dates										Black
15. Deceder (Specify only highe	nt's Education est grade completed)	16a	(Give	lent's Usi kind of w DO NOT i	ork done	during most o	f worki	ing	6b. Kind o	of Business/Ind	dustry
Elementary/Secondary (0-12)	College (1-4o	r 5+)	mo. L			fficer		M	etron	olitan P	olice Dept.
Father's Name (First, Middle,				101			Name	e (First, Middle, M.			
Richar	d H. Offord							Sallie B.	Watl	ey	
a. Informant's Name/Relations	ship (Type. Print)	198	b. Mailin	g Addres	s (Stree	t and Number	or Rura	al Route Number,	City or To	wn, State, Zip	Code)
Sheila K. Offor	d - Wife		70	09 We	11s P	arkway,	Hyat	ttsville, M	aryla	nd 20782	
a. Method of Disposition		20b. Place o	of Dispos		me of	1				on - City or To	
1 ☐ Burial 2 ☐ Cremation 4 ☐ Donathon 5 ☑ Other (\$		te		,		1	4/24	4/2009 S	ilver	Spring,	Maryland
1. Signature o Funeral Service	Licersee		H	ines-	Rinal	ess of Facility	al F	Home, Inc.			
/ dary	m/ Jui		1	1800	New H	ampshire	Ave	enue, Silve		ing, Mar	yland 20904
Ba. Part f. Enter the disease, o shock, or heart fallure Lis	r complications that caus t only one cause on each	ed the death. Do line.	not ente	-							Approximate Interval Between Onset and Death
nmediate Cause (Final sease or condition sulting in death)	a METT	75777710	_ (	110	DIA	NGIO (	AN	Ranom	A		
cally in dodin	Due to (or a	as a consequence	of):								
equentially list conditions,	b	as a consequence	of):								
any, leading to immediate luse. Enter Underlying ause (Disease or injury	\$ 500 10 101	a consequence	5.7.								
at initiated events sulting in death) Last	c Due to (or a	as a consequence	of):								
	u								1		
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal deat at time of death		Ectopic   Other (s		су			23d.	Date of delive Month	ery Day Year
art II. Other significant condit	ions contributing to death	but not resulting	in the ur	nderlying	cause gi	iven in Part I.		23e. Did toba	acco use	contribute to t	he cause of death?
								1 ☐ Yes	s 2 🗆 N	lo 3□ Prot	pably 4.☐Unknown
							_	24a. Was an autopsy perform 1∐ Yes 2	ed?	4b. Were auto prior to co death? 1 □ Yes	opsy findings available mpletion of cause of
. Was case referred to medica examiner?							r Deat	h (Check only one			
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa				OA			ome 5 ☐ Resider			(y)
. Manner of Death	28a. Date of li (Month, I		Time of Injury		28c. Inju	uryat ork? ⊒Yes 2 ⊒ No		28d. Describe how	w injury o	ccurred	
Natural 5 ☐ Pendi	9			M	71	Tres 21 INC					
Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide detern	igation	injury - At home, f etc. (Specify)	arm, str					28f. Location (Stre City or Town,	eet and N State)	umber or Rura	al Route Number,
2 Accident 3 Suicide 4 Homicide  a. Certifier	igation	st of my knowledg	je, death	eet, facto	ry, office	time, date and	place,	City or Town,	State) use(s) an	d manner as s	stated.

State Registrar

IASNEEM 31. Date filed (Month, Day, Year) 23

CAKHANI, MI) 32. Registrar's Signature backed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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SmITH

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BALD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 28 2009 5:07 AM Paula W. Phillips 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, May 10, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Days Min. Months Hours 1 □ M 2 X 52 Texas 220-74-9669 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Montgomery Montgomery Village 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 9419 Chatteroy Place United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 □Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Internet Technology Systems Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bill Wyatt Emily Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Phillips/Son 9419 Chatteroy Place, Montgomery Village, MD 20886 20b. Place of Disposition (Name of Me tropolitical Crematory or other place)
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition April 2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Onset and Death Immediate Cause (Final MSYSTOLE disease or condition resulting in death) Due to (or as a consequence of): effesion Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ~3 days Breast Cancer resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Tyes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

permit. Pages 1 and 2:
Department of Health an.
Important: If item 27 is m.
any injury or other\* **Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Certification: To

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modeal Examinar mast be notified at

72 hours after

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Baltimore, Maryland 21215-0036

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April 20,2009

signed by the attending physician and be detached for use as the burial-transit icate has been si this certificate spital or Attending Physician: Trours after death.
Ineral Director: After this certificat y filled in by the funeral director, p:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner?

(Check only one)

29b. Signature and title of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD

D 0066990

29c. License number

29d, Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinni Juneja, M.D., 6420 Rockledge Drive, Bethesda, MD 20817

State Registrar 31. Date filed (Month, Day, Year)

determined



To the Hospital within 24 hours a To the Funeral Completely filled

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year 36 PM 20177 Stephen Perin AV121L 10 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death JOHNE HOPKING BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 M 2 F Months Days Hours 215-46-4304 62 April 23, 1946 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 K Yes 2 □ No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10363 Cullen Terrace 21044 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Personnel & Policies Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Perin Sophie Esther Nerenberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlyn Perin - Wife 10363 Cullen Terrace, Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 04/13/2009 Columbia, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACATANIAL HYPERTENSION 12 4025 disease or condition resulting in death) Due to (or as a consequence of): 12 HRIPS INTRACRANIAL HEMDRRHAGIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Baltimore, Maryland 21215-0036

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P.O. Box 68760

Division of Vital Records,

Examiner Physician/Medical þ Completed Be Certification: To nours after death.

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Part II. Other significant conditions	contributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?  ☐ No 3 ☐ Probably 4 ☑ Unknown					
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No					
25. Was case referred to medical examiner?		26. Place of Death (Check only one)								
1 Yes 2 ✓ No	Hospital: 1 Inpatient 2 □	Home 5 ☐ Residence	6 ☐ Other (Specify)							
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati		28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	28d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		nome, farm, street, fact	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 ✓ Certifying F (Check only one) 1 ✓ Certifying F 2 ☐ Medical Example 1	Physician: To the best of my kn aminer: On the basis of examin	owledge, death occurr ation and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause(s curred at the time, date an	s) and manner as stated. d place, and due to the cause(s)					

29c. License number

785-000

State Registrar

NICOLE 31. Date filed (Month, Day, Year)

23

29b. Signature and title of certifier

EDMOND M.D. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parks

4940 EASTERN AVENUE Baltimor, NID 21224

29d. Date signed (Month, Day, Year)

APRIL 10,2009

DHMH 17 Rev 1/2001

To the Hospital c within 24 hours al To the Funeral C completely filled

B

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2208 Leanorah Powell 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Comm. Hospital Cheverly If Under 1 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)

Jamaica 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min 1 □ M 2 🙀 F 87 216-51-1387 6-7-21 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Exeminar must be notified at Director 1 XYes 2 ☐ No Md. P.G. Hyattsville 10e. Street and Number 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 6948 Greenvale Parkway 20784 Jamaica Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12th event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any lipiny or other traumatic event, other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjimen Harvey Idiama Williams 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herma Powell-Hall/Daughter 6012- Mustang Drive, Riverdale, Md. 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Keynsham Cemetery 5/2/09 Manchester, Jamaica 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Tye of Funeral Service Licensee 22. Name and Address of Facility The House of Williams F.S. 814 Upshur Street, N.W. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final AL **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner PD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed W and burial-trar Due to (or as a consequence of) attending physician for use as the hurial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 No o 9 Unknown ď. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ś Record 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 □Yes 1 ☐Yes 2 ☐ No Vital 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No this 1 Impatient 2 ER/Outpatient 3 DOA Certification: To ō funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation spital or Attendiours after death.

neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signatur# and title of certifier 29d. Date signed (Month, Day, Year) 1171Ch 055403 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1cete TAN, MD SURESH 7610 Carroll Ave. Takoma Pk. Md. 20912

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar Signatu

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Physici		ina-Quevedo  1- For State Registrar  1. Decedent's Name (First, Mi	State of Mary		rtificate of		and Men	12.	Re Date of Dea	eg. No. 2 th 2		Time of Beath
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Baltimore,	Page nent c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		e	raine	Park Cer	m.	4-28-200		altimore	
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_	ie deatl the atte hed for	sicia	in the past 12 months?  1 Yes 2 No	4☐Pregnant 9☐Unknown	at time of dea		Other (specify)				Month	Day Year
P.O.	at the de d by the etached	Phy	9 ☐ Unknowh  Part II. Other significant conditions c			Iting in the (	inderlying cause gi	ven in Part I	230	e. Did tobac	co use contribute	e to the cause of death?
	ires that signed b	Completed by Physician/Medi	1	vuin, D			H+W,	CVA.		1 🗌 Yes	2 No 3	Probably 4 Unknown
Division of Vital Records,	w requir been si shoufd I	ietec	00 0/11 1/10/1	Den De	neme	Co	Jenne Call	- A	10 20 24	a. Was an	24b. Were	autopsy findings available
Re	The law cate has page 2	duc	peymen vast	The state of the s		100	my an	7	15	autopsy performed Yes 25	prior d? death ANo 1 □ Y	
a		Be C	25. Was case referred to medical					26. Place	e of Death (Chec			
Š	hystoi this ce al direc	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗌 Inpa		R/Outpatie	nt 3 DOA		ursing Home 5[			Specify)
0	ding Ph h. After th funeral		27. Manner of Death  1   Solution Solu	28a. Date of Ir (Month, I	njury Day Year)	28b. Time o Injury	Wo	ryat ork? ]Yes 2.⊡		scribe how	injury occurred	
Sio	Attending Physician: sr death. actor: After this certifics by the funeral director, I	icat	2 Accident investigation 3 Suicide 6 □ Could not be		Injury - At hor	me. farm. si	treet, factory, office		28f. Loc	ation (Stree	at and Number or	r Rural Route Number,
Di≤	after Dirac	Certification:	4 Homicide determined	building,	etc. (Specify,	)	,		City	y or Tówn, S	State)	
	To tha Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely tilled in by the fu	aic	29a. Certifier Certifying Ph	ysicien: To the be	st of my know	viedge, dea	th occurred at the to	ime, date a	nd place, and due	to the caus	se(s) and manner	r as stated.
	in 24 tha Fu	edical	one)	and manner	stated.	- IOI AII WOI II			attrooding at the		. Date signed (M	
	To To corr	Σ	29b. Signature and title of certifier	d			D /	se number		230	4 12-310 G	
	`		20 Name and address of account	completed cause of	of death (Item	23a) (Type	Print)	704			1101109	,
(b)	100		30. Name and address of person who RUBELL LIBELS	My. 3)	UP B	arlz	St Bec	tro,	rul 2	1224	<i>f</i>	
	St	ate	31. Date filed (Month, Day, Year)	32. R/gi	strar's Signat	ure	6.41			/		
	Regist	rar	APR 24	CUUS CHE	war.	1. 19	parker					

DHMH 17 Rev 1/2001

			a roi	partment of Health and Menta ertificate of Death	Reg. No. 2009 14817								
	Physici		1. Decedent's Name (First, Middle, Last)  Geraldine Keenan Rubin		te of Death Day Year 3. Time of Death								
Salar S	/Medic Examir		4a. Facility Name (If not institution, give street and number)  18902 Monticello Dr.	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington County								
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday 82 Yrs.	) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min (Mr.	te of Birth onth, Day, Year) 1. 24, 1927 Pennsylvania								
	Maryland a-f show ified at	ctor	Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 □Yes 2∰No								
	th with the 23a or 28 ust be no	ral Dire	10e. Street and Number 18902 Monticello Dr.	10f. Zip Code 21742	10g. Citizen of What Country? U.S.A.								
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if "Modical Evaminer must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 🏠 No Specify:	14. Race - American Indian, Black, White, etc.  Specify: White								
21215-0036	within 72 ho jiene. r <b>than "natur</b> fre Medical	ompletec	(Specify only highest grade completed) (Giv life.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) etery	16b. Kind of Business/Industry Aluminum MFG								
Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Robert Keenan	18. Mother's Name (First, Marie Drehe	, Middle, Malden Surname) er Keenan								
	nd 2 sho alth and 27 is m er traum			ling Address <i>(Street and Number or Rural Rout</i> 08 Wood Hill Dr. Hager									
Baltimore,	Pages 1 ar nent of Hea ant: If item 3 ury or other		4 □ Donation 5 □ Other (Specify) Smithsbu	position (Name of ematory or other place)  rg Crematory 4-24-200									
Balt	permit, Depart Import any Inj once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral 1331 Eastern Blvd. North Hagerstown, MD										
4	Physician /Medical		23a. Part 1. Enter the disease, or confining that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):										
8760,	physician and purial-transit	dical Examiner	Se yentially list conditions, is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of).  Due to (or as a consequence of).	sky Dueshe	YEARS								
.O. Box 6	w requires that the dirath certifin been signed by the attending is should be detached for use as	Completed by Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year								
Records, P.	equires that sen signed b ould be deta	ted by Pł	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	3e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown								
al Rec	n; The law I ficate has b ir, page 2 sh		- 5M & OLI	11	4a. Was an autopsy findings available prior to completion of cause of death?  □ Yes 2 □ No 1 □ Yes 2 □ No								
of Vit	ding Physician: The h. After this certificate h funeral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Chec ent 3 □ DOA Other: 4 □ Nursing Home 5	ck only one)  Residence 6 □ Other (Specify)								
Division of Vital	To the Hospital or Attending Physician: The law requires that the dwath certificath within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To	27. Manper of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 28b. Time of Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred										
	he Hospita in 24 hours he Funera ipletely fille	29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Monti											
	To T Com	Σ	29b. Signature and title of certifier  Description:  Description:	29c. License number	29d. Date signed ( <i>Month, Day, Year</i> ) 4/23/09								
H	1-6.		30. Name and address of person who completed chise of death (Item 23a) (Type PAME LA FOL BRANFORD M)	Print) IIIO MEDICAL C HAGERITOUN,	MD 21742								
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2.7 3003  32. Registrar's Signature	Sac !									

		State of Maryl		ertment of He			200	0 11.01
		Registrar		runcate of D		Reg. No. 1	40. <u>ZUU</u>	3. Time of Death
Physi /Med	ician dical	Nat Ross					Day Year	
Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L		1 4	4c. County of Dea	
		Washington County Hospital			rstown		Washing	
Funera Directo	_	5. Social Security Number 133-03-0276  6. Sex 1 ☑ M 2 ☐ F 7. Age (In	yrs. last birthday 95 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yea	ar) C	irthplace (State or Foreigr Country) <b>ew York</b>
pui		Usual Residence of Decedent  10a, State 10b, County 10c	City, Town or L	ocation				10d. Inside City Limits
laryla sho	2			alm Beach				1 X Yes 2 □ No
the N	Director	10e, Street and Number	WCSC I	10f. Zip Code		10g.	Citizen of What C	Country?
with with the same					3417		USA	
death	Filheral	11. Marital Status 12. Was Decedent Ever	n U.S. 13	. Was Decedent of His If Yes, specify Cuban,		fy Yes or No-	14. Race - Am	nerican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  Important: I file m 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tre Medical Exeminer must be rediffed at	PV Fil	If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:			, Mexican, Puerto Ric Specify:	can, etc.)	Specify: V	ite, etc. vhite
2 hou	tod	15. Decedent's Education	16a. Dec	edent's Usual Occupati	ion	16b.	. Kind of Busines:	s/Industry
thin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	life.	e kind of work done du DO NOT use retired)	ning most of working			
ed wii ygien ygien t, tre	ز	12 0	let	ter carrier			ost off:	ice
be fill tal H d oth	å	17. Father's Name (First, Middle, Last)		1	18. Mother's Name (F	_	en Surname)	
y IC	Ę		1		Dora Wolk			7: 0: 1:1
d2sh than than 7 Isr		19a. Informant's Name/Relationship (Type. Print)  Ronald Ross - son	1	ling Address <i>(Street an</i> 7 L <b>indsa</b> y I			-	· · · · · · · · · · · · · · · · · · ·
1 an Heal Hern tern 2				osition (Name of ematory or other place)			Location - City o	
Pages ent of nt: If i		I I Burial 2 Last remation 3 Li Removal from State 1		ematory or other place) wn Cremato		09 н	agerstow	m, Maryland
mit. F partm porta	9	21. Signature of Funeral Service Licensee		22. Name and Address		NNICH FU		
2 88 5 6	ouce	(rabille Sech		415 E. Wil	son Blvd.	, Hagers	town, Md	1. 21740
		23a, Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	leath. Do not e	1 -	Torra control			Approximate Interval Between Onset and Death
Physicia	_	Immediate Cause (Final disease or condition a.	eleller	of mu	monih	/		60095
/Medica Examine	_	resulting in death)  Due to (or as a cor	sequence of):	. /				
	•	Sequentially list conditions, b.  Due to (or as a condition)	sequence of:					
uted d ansit	١	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
exection and and ital-tra	Examiner	resulting in death) Last	sequence of):					
cate be executed physician and the burial-transit	dical	d						
	Ped	IF FEMALE:						
leath certific attending p	sician/Me	23b. Was decedent pregnant   23c. If yes, outcome of prediction in the past 12 months?   1 Live birth 2	Fetal death 3	☐ Ectopic pregnancy			23d. Date of d Month	lelivery Day Year
the a	Sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)				Suy Vol.
ires that the de signed by the	Phys	Part II. Other significant conditions contributing to eath but not	resolting in the	underlying cause given	in Part I.	23e. Did tobaco	o use contribute	to the cause of death?
uires uires rasign d be	þ	Durentia. 1pm	and	un )		1 ☐ Yes	2 4HO 3	Probably 4 ☐ Unknown
w require been signature should b	e e	//				24a. Was an	24b. Were	autopsy findings available
he law te has	Completed					autopsy performed	? prior to death?	o completion of cause of ?
an: T tifficat tor, pa	a)	25. Was case referred to modical	/		26. Place of Death (	1 □Yes 2 ☑ Check only one)	No 1 1 1	es 2 No
ysici is cer direct	0.0	1 Yes 2 No Hospital:	2 ☐ ER/Outpation	Other			e 6 ☐ Other (S)	pecify)
ng Ph fer th		27. Manner eath 28a. Date of Injury (Month, Day, Yea	28b. Time	of 28c. Injury a	at 28	d. Describe how in		
endir sath. or: Af	atic	2 Accident investigation	, , , , ,		es 2□No			
or Att ter de irecte	ertification: T	3 ☐ Sulcide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Single Place)  City or Town						Rural Route Number,
urs all	O		1				/·>	
To the Hospital or Attending Physician: The law requires that the death certification of the Hospital or Attending Physician: The law requires that the death certificate that the tuneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifler 1 Certifying Physician: To the best of my (Check only one) Medical Examiner: On the basis of examiner one)						
Vithin To the comp	Z	29b. Signature and title of certifier		29c. License			Date signed (Mo	
		DAMUEL CHAN		D 366	355	Ar	ml 24	, 4009
		30. Name and address of person who completed cause of death	(Item 23a) (Type		111.	foun, n	10217	110
3H-1+1		524 EAST AN WETAM SI	ret. I	2118 200.	togles	town "	111 311	40
S Regis	State strar	31. Date filed (Month, Day, Year)  32. Registrar's S	ignature 	1				
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Registrar

JACKIE JONES,

APR 23

31. Date filed (Month, Day, Year)

CRNP

2009

JUDITH RAFFEI

**ORIGINAL** 

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

**Physician** 

Examiner

Director

Completed by Funeral

Be

ပ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, it is the filed Exaction of the traumatic event, it is the filed Exaction of the filed exaction.

Baltimore, Maryland 21215-0036

/Medical

or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Examine Physician/Medical 2 Completed Be Medical Certification: To

in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		er (specify)	Month Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical		(Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3	ne 5 Residence 6 Other (Specify)	
27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	8d. Describe how injury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office 2	8f. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occi niner: On the basis of examination and/or investig and manner stated.		and due to the cause(s) and manner as stated.  ed at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	ti, MD	29c. License number D 0 0 6 0 1 0 0	29d. Date signed (Month, Day, Year)  UG - 22 - 9

State Registrar

DHMH 17 Rev 1/2001

within 24 hours To the Funeral

South

32. Registrar's Signature

hirestop

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 4/30/2009 2:38 A Mabel Rahe Rippons /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Chesapeake Woods Center Cambridge Dorchester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 X F Yrs 6/22/1923 New York Director 145-18-0024 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral, or iteme 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Director Cambridge Maryland Dorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** permit. Pages 1 and 2 should be filed within 72 hours atter death v Department of Health and Mental Hydiene. important: If item 27 le marked other than "natural", or Iteme 23a any injury or other traumatic event, the Medical Examinat must once. 406 Aurora Street 21613 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Planner Planning and Zoning 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Rowley Joseph Zacpal 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1908 Pig Neck Road, Cambridge, MD 21613 Evelyn Rahe Renkwitz / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 05/04/2009 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licer Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 2161 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Metastanz Onset and Death Rectal Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 99 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed: 1 Tes 2 3 Ho 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifice 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Tes 2 10 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5 - /4/30/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

DHMH 17 Rev 1/2001

State Registrar

NOMAN

31. Date filed (Month, Day, Year)

503

32. Regisfar's Signature

ST CAMBRIDGE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ( For State Registra AMEND # 2 perMD4 - 30 - 09, BMW, Mertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da**] 4** Physician 2:50 pM Malvin Dean Steinback, Jr. April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4509 32nd Street Mount Rainier Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2□ F Director 577-76-2933 Maryland 55 December 27,1953 Usual Residence of Decedent the Maryland show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho event, the twelfest Evanieur must be notified at Director 1 ☐ Yes 2 K No Mount Rainier Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4509 32nd Street 20712 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 
If Yes, Give
Year or Dates: or 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: 2 Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wh. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Clerk U.S. Postal Services marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill Health and Mental H Im 27 Is marked ott Be Malvin Dean Steinback, Sr. ဂ Patricia Ann Simms 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 & Department of Health ar Important: If Item 27 Is any injury or other trau Patricia A. Steinback - Mother 1330 Sheridan Street, Washington, D.C. 20011 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 Removal from State Fort Lincoln Crematory 4 Donation 5 ☐ Other (Specify) 04-20-2009 Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Ligense 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the dise use or complications that caused the death, shock, or heart failure list only one cause on each line. Approximate Interval Between Onset and Death Do not enter the m of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Records, P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE: f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ robably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy Physician: The perform certificate 2 2 🗆 No Division of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Desidence 1∐ Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 D Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident vithin 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the bear of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and prayner stated (Check only one) To the I within 2 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of per

31. Date filed (Month, Day,

APR

Wayne Frederick, M.D.,

Year)

23

2041 Georgia Avenue, NW, Washington, D.C.

son who completed cause of dearn (item 23a) (Type, Print)

3 Registrar's Signatu

MD 30905

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			State of Maryland / State Registrar		artment of H		nd Ment		ne N200	9 14	823
			Decedent's Name (First, Middle, Last)					ate of Death			ne of Death
	Physicia /Medic		Barbara Brown Shea				Api	ril :	$2\overset{\text{Day}}{2}$ $2\overset{\text{O}}{0}$	39 4:5	5 A M
1	Examin		4a. Facility Name (If not institution, give street and number)  Mandrin Hospice House		4b. City, Town, or Harwoo	_	Death		4c. County of E		
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last t	oirthday)	If Under 1 Year	If Under 24	Hrs. 8. Da	ate of Birth		Birthplace (Sta	ate or Foreign
	Director		266-36-8326 1□M 2XF 85	Yrs.	Months Days	Hours	Min. May	ate of Birth Nonth, Day, Ye y 7,19	23 Co	olorado	
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Lo	cation					10d. Insid	le City Limits
	Maryla f sho	ō			rnold					1 🗆 '	Yes 21 No
	r 28a	irec	MD Anne Arunde1  10e. Street and Number	A	10f. Zip Code			10g	. Citizen of Wha	t Country?	
	23a o	ralD	641 Oakland Hills Drive B-1		21012			1	United S	States	
36	be filed within 72 hours after death with the Maryland at Hygiene.  did Hygiene.  dether than "natural", or items 23a or 28a-f show event, I'm Itedical Eror instruction for notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2ሺ No	spanic Origii n, Mexican, I Specify:	n? (Specify Y Puerto Rican,	es or No- , etc.)		American India: Vhite, etc. White	n,
9500-6121	2 hour	ted	15. Decedent's Education	a. Dece	dent's Usual Occupa	ation		16	b. Kind of Busin	ess/Industry	
7	thin 7 ne. Ian "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+  No		kind of work done of OO NOT use retired						
7	led wi Hygier her th			atio	nal Secur				.S. Gove	rnment	
land	e d da	o Be	17. Father's Name (First, Middle, Last)  Ervin T. Brown				ge Harl		den Sumame)		
ar y	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	2		9b. Mailir	ng Address (Street a	and Number	or Rural Rou	te Number, C	City or Town, Sta	te, Zip Code)	
, Mai	5 # 2 #				ostwick L	ane, (	Gaithe				
ש	Pages 1 annent of Heannent of Heannent of Heannent II item		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  20b. Place 20eme Metro	of Dispo	sition (Name of natory or other place Lan	e)	Date <b>ril</b> 22	I .	c. Location - City	/ or Town, Stat	е
Saltimor	it. Pae rtmen rtant: njury		4_Donation 5_Other (Specify)   Crem	nator	y	: 2	009	AI	exandri		
n D	permit. Pages Department of Important: If i any injury or once.	6 8	21. Signature of Funeral Service Licensee			Gaithe	ersburg	g, MD	20877		
			23a. Part 1. Enter the disease, or complications that caused the death. D sheet, or heart failure. List only one cause on each line.			_	ardiac or resp	oiratory arrest	,	Onset a	l Between and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)		) SNEAS	7				19)	y125
	Examiner		·	J - 1,1							
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury								
>	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c	e of):				_			
/60,	e be e sician buria	dical E	d	,.							
ΩΩ	tificati ng phy as the	ledic	0.					•	1	- N-	
C. BOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.  To the Funneral Director. After this certificate has been signed by the attending physician and to the Funneral Director, the funneral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 No  9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)	/			23d. Date o Month	,	Year
7.	ned by	by Ph	Part II. Other significant conditions contributing to death but not resulting	j in the u	nderlying cause give	en in Part I.	2	3e. Did tobac	cco use contribu	te to the cause	of death?
ecords,	en sig	ed b					_	1 🗆 Yes	\$45 No 3[	Probably 4	Unknown
Hecc	The law re cate has be page 2 sho	Completed					_	4a. Was an autopsy performe	d? prio	re autopsy findi r to completion th? Yes 2 □ No	of cause of
N [a	ician: Sertific ector,	Be (	25. Was case referred to medical examiner?		Othe		of Death (Che			17.	
5	Phys r this ral dir	P.	1 Tes 2 ER/0	Outpatier  Time of		4 🗀 Nurs			injury occurred	00001197	OUSE
0	th. : After	tion	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	Injury	Work	Yes 2∐No		rescribe now	injury occurred	17	
DIVISION OF	I or Atter after dea Director d in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Lo	ocation (Stree ity or Town, S	et and Number o State)	or Rural Route	Number,
	e Hospita 24 hours e Funeral letely fille	Medical C	29a. Certifler (Check only one)  1								rse(s)
	vithir to comp	Me	29b. Signature and title of certifier		29c. License	e number	Ų.	29d	. Date signed (A	fonth, Day, Yea	ar)
	15		Att / Notting		Do	8118	5	/A	UNITS.	2 200	5. 8.
			30. Name and address of person who completed cause of death (Item 23a 900 B) 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 23 2009	a) (Type,	Print)	n 2	1401	STHA	burs W	ATKIN:	(אונא צ
	Sta Registr	_	31. Date filed (Month, Day, Year) 22. Registrar's Signature	par	Ked						
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		for State		State of Ma	arylan			Health and N			0 11 021	
		RegistrarAME		,4-27-09,BMW	,MbCo	Ce	rtificate of	Death —————		Reg. No. 200	3 14824	
Phys	ician	Decedent's Name			Canada	_			2. Date of Dea Month	Day Ye	10.20 014	
	dical	4a Facility Name (		ohn Raymond ve street and number)	Scott	-	4h City Town o	r Location of Death	Apri1	19 200 4c. County of D	,,	
Exar	miner			eral Hospital			4b. Oity, IOWII, O	Olney		,	ontgomery	
Funer	ral	5. Social Security N	lumber 6.	Sex 7. Ag		ast birthday)		If Under 24 Hrs.	8. Date of Birt (Month, Da	h 9.	Birthplace (State or Foreign Country)	
Direct	_	234-36-7	015	1 <b>⊠</b> M 2□ F	86	Yrs.	Months Days	Hours Min.			est Virginia	
and w		Usual Residence of 10a. State	Decedent  10b. County		10c City	, Town or Lo	ocation				10d. Inside City Limits	
/laryla fsho edat	ō		School L		,	,		Rockville			1 □Yes 2 🕱 No	
the f	Director	Maryland  10e. Street and Nur	Montgo mber	omery			10f. Zip Code	KOCKVIIIE		10g. Citizen of What	Country?	
3a or	D D	14107	Heathfiel	d Court				20853		ī	J.S.A.	
deatl	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		3. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - A Black, W	merican Indian,	
after after mine			ied 2 🕱 Married	1 Karyes 2 ☐		- /	1 □Yes 2 No		r rioding over	Specify:	Title, etc.	
hours ural"	A D			Year or Dates:	Kore		d#- 111 O			16b. Kind of Busine	Caucasian	
n 72	lete	(Spec	15. Decedent's E cify only highest gr	ade completed)		(Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of work	king	160. KING OF BUSINE	ess/madstry	
withi giene.	Completed	' Elementary/Seco	ondary (0-12)	College (1-4or 5	ō+)		Teach	Ť		Edu	ication	
e filed other other,	BeC	17. Father's Name	(First, Middle, Las	t)				18. Mother's Nam	e (First, Middle,	Maiden Surname)		
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. In Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show umaffe event, the Mental Emininer must be notified at	2		John R.	Scott					Joanna	J. Dye		
2 sho and a ma		19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, Sta	te, Zip Code)	
and and m 27 her tr		-	A. Scott -	Wife	1					Maryland 208		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumaft event, Ita Muddel Examiner must be notified at		20a. Method of Disposition 1 🗷 Burial 2	•	Removal from State	20b. Pl	ace of Dispo emetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location - City	or Town, State	
it. Pa			5 ☐ Other (Spec	***	Gat		eaven Cemet		23/2009	Silver Spr	ing, Maryland	
Depart Impo	once	21. Signature of Fu	Ineral Service Lice	ensee		H		i Funeral B			Variant 2000/	
		23a, Part 1, Enter t	he dise se, or con	nplications that caused	the death					A	Mary1and 20904 Approximate	
Dhysisia		shock, or hea Immediate Cause	irt fa ur. List only	/ one cause on each 🖿	ne		7			,	Interval Between Onset and Death	
Physicia /Medic		disease or condition resulting in death)	on 🕜	a. Due to (or as	a consequ	ence of):						
Examin	er			a. Carl Due to (or as	dur	1/0/0	thy				10 years	
₽ .±	<u>ē</u>	Sequentially list conditions, if any, leading to him bulate cause. Enter Underlying Cause (Disease or injury				istros Uty:					7	
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rtificate by physic as the b	Physician/Medical			d								
eath certi attending for use a	Ž	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome						23d. Date of	delivery	
death death d for	icia	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a			☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		Month	Day Year	
that the de led by the detached	hvs	9 ☐ Unknown		9 ☐ Unknown								
be ig	Ş	Part II. Other signif	ficant conditions	contributing to death b	out not resu	lting in the ເ	underlying cause giv	ven in Part I.			e to the cause of death?	
w requir s been s should	ted	1							1 🗆 1	/es 2 No 3 □	Probably 4 🗹 Unknown	
e 2 st	Completed			. <del></del>					24a. Was autor	osv / prior	e autopsy findings available to completion of cause of	
									1 □ Yes	rmed?/ deat 2. ZNo 1 □	nr Yes 2 □ No	
Physiclan: r this certific ral director, p	Be	25. Was case refer examiner?		Hospital:			Oth	26. Place of Dea				
ding Physin. The After this of tuneral directions.	5.	1 ☐ Yes 2 ☑ 27. Manner of Deat		28a. Date of Inju	ıry	28b. Time of				dence 6 Other (	Specify)	
Attending r death. ector: After by the funer	igi	1X Natural 2 ☐ Accident	5 Pending investigation	(Month, Da	ay, Year)	Injury	Wor	rk? ]Yes 2 □ No		,		
Atter ar dea ector by the	Hick	3 ☐ Suicide 4 ☐ Homicide	6 Could not I	28e. Place of Inj	ury - At ho	me, farm, st	reet, factory, office		28f. Location (S	Street and Number o	r Rural Route Number,	
tal or s afte al Dir	Certification:	4   Hornicide		building, et	.c. (Specif)	'/			City or Tov	vn, Statej		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical	29a. Certifier (Check only one)		hysician: To the best miner: On the basis of and manner st	of examinat							
Fo the vithin Fo the comple	Med	29b. Signature and	title of dertifier	Saullin			29c. Licens	se number		29d. Date signed (M	ionth, Day, Year)	
14+		1	1/	1			D 33	3067		April 10	1th 2009	
///		30. Name and addr	ress of person who	completed cause of c	death (Item	23a) (Type,	, Print)					
				, M.D., 1810			ip Drive, S	Suite 225, 0	Olney, Mar	yland 20832		
	State istrar	31. Date filed (Mon		19 Pen in	ars Signal	bar	Kel.					
				17"	-							

			For State Registrar		State of Ma	aryland / [	Depa <i>Ce</i> a	artment of F <i>rtificate of I</i>	lealth ai <i>Death</i>	nd Mer		ene 20	09	14825
	Physici	an	1. Decedent's Name		,						Date of Death Month	Day	Year	3. Time of Death
No. of	/Medic	al	Georgiann					4 0 =	1 1 1	A	pril 18	3, 2009		3:35 P M
and the same	Examin	er	Kline Hos		give street and number)			4b. City, Town, or Mt. Air		Death		4c. County		
	Funeral		5. Social Security Nur	mber 6		(In yrs. last bir		If Under 1 Year Months Days	If Under 24	4 Hrs. 8. I	Date of Birth (Month, Day,			place (State or Foreign ntry)
	Director		Usual Residence of D		TE M ZLAF	54	Yrs.			Ji	nly 14,	1954	Mary	land
	yland how			10b. County		10c. City, Tow	n or Lo	ocation					1	I 0d. Inside City Limits
	sa-fs	Director		Frederi	ck	Frederi	_ck							1 □Yes 2 No
	172 hours after death with the Maryland "natural", or items 23a or 28a-f show cdirel Examinar nast be notified at	al Dir	10e. Street and Numb		<i>7</i> e			10f. Zip Code 21 704				g. Citizen of W SA	hat Coun	ıtry?
	tems ;	Funeral	11. Marital Status		12. Was Decedent 8 Armed Forces? 1 □ Yes 2 1 N	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	lispanic Originan, Mexican, I	in? (Specify Puerto Rica	Yes or No- an, etc.)		e - Americ	can Indian, etc.
036	urs afte al", or i Examir	þ	1 ☐ Never Married 3 XWidowed 4		d 1 ∏Yes 2 [7]N If Yes, Give Year or Dates:	lo		1 □Yes 2XINo	Specify:			Specify:	Whi	te
15-0036	72 ho "natur	Completed	1 (Specify	5. Decedent's y only highest	Education grade completed)	16a	(Give	dent's Usual Occup kind of work done of	durina most o	of working	1	6b. Kind of Bu	siness/Inc	dustry
12	withir ene. <b>than</b>	omp	Elementary/Second		College (1-4or 5-	+) As		DO NOT use retired hbly Line	_	r	I	actory	r	
nd	e filed al Hygi l other vent, II	Be C	17. Father's Name (Fi		,				18. Mother's	's Name <i>(Fil</i>		aiden Surname	e)	
<u>yla</u>		ျှ	Nelson Ow						_		e Mille			
Maryland 2	tra tra	2 0	19a. Informant's Nam	,	(Type. Print) A/Executor			ng Address <i>(Street i</i> <b>) Walnut (</b>				-	-	
re,	the He		20a. Method of Dispos	sition	· · · · · · · · · · · · · · · · · · ·			sition (Name of matory or other place		Date		Oc. Location -		
Baltimore,	Pages tment of tant: If it tany or o		1 □ Burial 2 🗗 4 □ Donation 5	Cremation 3 ☐Other (Spe	☐ Removal from State cify)	W. Aru	inde	el Cremato	ory 0	4/23/	09 00	denton,	MD	
ga	permit. Pag Department Important: I any injury o		21. Signature of Fund	eral Service Lic	censee / //		1	Home						
F			23a. Part 1. Enter the	disease, or co	omplications that caused ally one cause on each line	the death. Do							ште	Approximate Interval Between
4	Physician		Immediate Cause (Fi		ny one cause on each in	A3451	ble							Onset and Death
	/Medical Examiner		resulting in death)	1	Due to (or as a	conse quence	1							1
		je.	Sequentially list condi	itions, ediate	b. Due to (or as a	consquence	of):						-	days
	ecuted and transit	Examiner	Sequentially list condi if any, leading to imme cause. Enter Underly Cause (Disease or Inj that initiated events resulting in death) Las	jury	с			nea			,		,	days
b&/ bU,	ificate be executed g physician and as the burial-transit		roodking in doddin Edi		Due to (or as a	consequence	01):" [MC 8	sis, Intr	netabl	le pain	, Mela	alignan noma		meek
20		Medical	IC CENALE		d					//				
X Q	leath certific attending p	ian/	IF FEMALE: 23b. Was decedent print the past 12 me	regnant	23c. If yes, outcome of	2 🗆 Fetal death		Ectopic pregnancy	y			23d. Date	e of delive	ery Day Year
5	the de	Physician/M	1 □ Yes 2 🔯 N 9 □ Unknown	No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ∟	Other (specify)				, inc,		
ν̈́ L	es that gned k	by P	Part II. Other significa	ant conditions	s contributing to death bu	t not resulting in	n the ur	nderlying cause give	en in Part I.		23e. Did toba	icco use contr	bute to th	he cause of death?
ecords	requir been s					<del></del>				_	1 🗌 Yes	3 No	3 Prob	bably 4 ☐ Unknown
Hec	he law e has t ige 2 s	Completed								_	24a. Was an autopsy performe	p	Vere auto rior to cor eath?	opsy findings available impletion of cause of
	ian: T	Be C	25. Was case referred	d to medical					26. Place of		1 ☐ Yes 2 heck only one		□Yes	2 No
>	hysic this ce al direc	၉	examiner?	٥	202	nt 2 ER/Ou	<u> </u>			sing Home	5 ☐ Residen	ce 6 🗷 Othe	r (Specif	<sub>(y)</sub> hospice
	ding F h. After funera	tion:		5 Pending investigat	28a. Date of Injur (Month, Day,	y ; <i>Year)</i> 28b. 1	Time of njury	Work	yat <br Yes 2∐No		Describe how	injury occurre	:d	
VISION OF	Atten er deat rector; by the	Certification:	2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide	6 Could not determine	be an Place of Injur	ry - At home, fa	rm, stre			28f.	Location (Stre	et and Numbe	er or Rura	al Route Number,
5	oital or urs afte eral Dii			-27-	y .						City or Town,			
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours atter death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1[ (Check only 2[ one)	_XCertifying  ☐ Medical Ex	Physician: To the best o aminer: On the basis of and manner stat	examination an	e, death id/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and occurred a	due to the car it the time, dat	use(s) and ma te and place, a	nner as s ind due to	stated. the cause(s)
	To the comp	ž	29b. Signature and titl	le of certifier	1/2	MP		29c. License				d. Date signed		
)	0 - 0	-	<b>P</b>		Mu				0674		-	ril 22		J <del>9</del>
k	26.6.			Yun A	io completed cause of de	Thom	(Type, I	Print) Johnson D	s Fr	ederi	ck, Mi	2170	2	
	Stat		31. Date filed (Month,	APR 2	32. Registra	r's Signature	1	1						
	Registra	r			Lour Mene	un p	. 19	parke						

/Medical **Examiner Funeral** Director filed within 72 hours after death with the Maryland 28a-f show Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Externings inset the notified at Director Baltimore, Maryland 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; if item 27 is marked other than " Be ပ Physician /Medical Examiner P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20009 1:10 РМ Ellen Elizabeth Stahl Apri1 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 16715 Buford Dr. Washington County Williamsport Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Hours Days 1 M 2 TF Yrs Sep. 22.1931 220-28-3745 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b, County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 👿 No Maryland Washington County Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 16715 Buford Dr. 21795 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify Specify: White 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Co-Owner Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William G. Iseminger Elsie Elizabeth Rhodes Iseminger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Stahl-daughter 16715 Buford Dr. Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4-27-2009 | Hagerstown, Maryland 4 Donation 5 Other (Specify) Rest Haven Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease of combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 66 months disease or condition resulting in death) Due to (or as a cons a uence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): pital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the functeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 □ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifig Name and address of person who completed cause of death (Item 23a) (Type, Print 3H-5 WI,

Registrar DHMH 17 Rev 1/2001

State

Division of Vital Records,

istrar's Signature

P.O. Box 68760 Division of Vital Records

	-	1 - State Registra/AMEND#25perMD4/23/09, BMV,		Certificate of L		Reg	ı No. 2009	14827			
Physicia	ın	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month April 19	Day Year	3. Time of Death			
/Medic	al	Marcelle S. Tennenba		14.00		April 19	4c. County of Death	11:16P M			
Examin	er	4a. Facility Name (If not institution, give street and numbe 5422 Wild Turkey Lane	)	Columbi	Location of Death		Howan	_			
Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birt	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)			
Director		117-32-3680 1□ M 2X F	68	Yrs. Months Days	Hours Min.	October	16, 1940	France			
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits			
rsho	ō	MD Howard	Columb					1 X Yes 2 □ No			
the N 28a-	rect	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	intry?			
3a or	٦	5422 Wild Turkey Lane		2104	4		United Sta	ites			
death	Funeral Director	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No-	14. Race - Amer Black, White				
ours after al", or its	þ	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2X If Yes, Give Year or Dates	] No	1 □Yes 2 XNo	Specify:	, 110411, 010-7		nite			
72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation Juring most of workir	ng 16	6b. Kind of Business/I	ndustry			
vithin sne.	du	Elementary/Secondary (0-12) College (1-4or	5+)		)		D-4-1				
Hygid V		17. Father's Name (First, Middle, Last)		Manager	18. Mother's Name		Retail aiden Surname)				
d be ental ked o	To Be	Pincus Aiss			Rebecca	Mirowich					
shoul and M mar	F	19a. Informant's Name/Relationship (Type. Print)	19b.	. Mailing Address (Street a	and Number or Rura	al Route Number, (	City or Town, State, Z	ip Code)			
and 2 and 2 salth a n 27 is er tra		Robert Tennenbaum - Husban	d 54	422 Wild Tur	key Lane	Columbia	MD 21044				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the incident Evantment to active the process.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of cemeter.	Disposition (Name of ry, crematory or other plac ia Mem. Park	<sup>e)</sup> 4/21/	2009 C	olumbia, N				
permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	01163	22. Name and Address Edward Sag	ss of Facility el Funera ckville P	l Direct ike Rock	ion Inc VIIIIe MD	20852			
Physician /Medical Examiner	- G	resulting in death)  Due to (or a	ad the death. Do n line.  A consequence of a consequence	not enter the mode of dyin				Approximate Interval Between Onset and Death			
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
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The law requir	Completed	V 1				24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of			
ician: Th	0	25. Was case referred to medical			26. Place of Death		A	2 □No			
is is	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpa	tient 2 ER/Ou	tpatient 3 DOA Othe	ar.		ce 6 Other (Spe	oify)			
- 6 6 G		27. Manner of Death  Natural 5 Pending  28a. Date of Ir  (Month, I	jury 28b. T Pay, Year) Ir	Time of 28c. Injury Work	(? _	28d. Describe how	injury occurred				
To the Hospital or Attending within 24 hours after death I to the Funeral Director: After completely filled in by the fune.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building,	njury - At home, far etc. <i>(Specify)</i>	M	Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,			
Hospital 24 hours a Funeral etely filled	Medical Co	29a. Certifier (Check only one)  29 Medical Examiner: On the basis and manner:	of examination an								
Fo the vithin Fo the comple	Mec	29b. Signature and title of certifier	nutou.	29c. Licenso	e number	290	d. Date signed (Mont	h, Day, Year)			
150		4. Dan Stum ont	7	DA	06.1600	4	04/201	2009			
7		30. Name and address of person who completed cause of Yuanjue Louann Zhang MD 1	death (Item 23a) (	(Type, Print) tle Patuxent	Parkway	Columbia	MD 21044	~~·			
Stat Registra		31. Date filed (Month, Day, Year)  1 APP 23 2009	trar's Signature	pares							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Steven Michael Tyler Sr. APRIL 24, 2009 8:00 a.™m 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Boonsboro Reeders Memorial Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours Min. 1 X M 2 □ F Yrs. 2, 1948 61 Maryland April 062-40-5111 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No Boonsboro Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21713 141 South Main Street 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married black 1 ☐ Yes 2 ☒ No Specify Specify 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) trucking driver 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joyce Evelyn Williams Charles Robert Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 445 Summit Ave., Hagerstown, Md. 21740 Steven M. Tyler, Jr. - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/28/09 Williamsport, Md. Greenlawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 00 Saprin disease or condition resulting in death) Due to (or as a consequence of): 7 e Slip Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown sigkentenia Cardionzopots 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 4 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 4NO 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 - Natural 5 Pending M 1 ∏Yes 2 ∏No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, this certificate has

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100

31. Date filed (Month, Day, Year)

- retemo

29b. Signature and title of certifier

APR 27 2009



29c. License number

7) 18015

29d. Date signed (Month, Day, Year)

APRIL 24 2009

			For State Registrar	State of Mic	ai yiai iu i		rtificate of			eg. No.	7 1402	
	Dh i - i		1. Decedent's Name (First, Middle, La	ist)					2. Date of Deat		3. Time of Death	
	Physici /Medi			ALBERT	EUGE	NE	THOBOI	S	April	19 2009		1
	Examir	er	4a. Facility Name (If not institution, given	ŕ				or Location of Death		4c. County of Dea		
an are			Frederick Memor: 5. Social Security Number 6.5		al e (In yrs. last	hirthday)	Freder If Under 1 Year		8. Date of Birth	Freder	ICK rthplace (State or Foreign	
	Funeral Director			EL OF	93	Yrs.	Months Days	Hours Min.	June 8,	Year) C	st Virginia st Virginia	
	/land		10a. State 10b. County		10c. City, T	own or Lo	cation				10d. Inside City Limits	3
	a-fsh	ctor	Maryland Freder	ick		N	ew Market				1 □ Yes 2 ☒ No	)
	th the	jre	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	ountry?	_
	23a	ra [	6842 Boyers Mill	Road			217	74		United S	States	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, then "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventine, must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent 8 Armed Forces? 1			Was Decedent of H If Yes, specify Cuba I □Yes 2⊠ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race - Am Black, Whi Specify:		
21215-0036	2 hou latura ical E	ted	15. Decedent's E	ducation	1 1	6a. Dece	dent's Usual Occup	pation		16b. Kind of Business	s/Industry	-
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gu	be fill htal H od oth even	Be	17. Father's Name (First, Middle, Last					18. Mother's Nam	e (First, Middle, N	Maiden Surname)		
ž	should be f and Mental I s marked of umatic eve	은	Clement Theophil						eline Bo			_
Maryland	d 2 sh than than 7 Isr traur		19a. Informant's Name/Relationship ( Deborah L. Mount		İ		•			; City or Town, State,	-,	
	Health tem 27 I		20a. Method of Disposition	/ Daughter			sition (Name of natory or other place			ket Mary 1		_
Baltimore,	permit. Pages 1 am Department of Heal Important: If item 2 any Injury or other once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	(y)	1	Olive	t Cemete	$ry \mid 24$ ,		Frederick	, Maryland	
Ba	permi Depa Impo any Ir once		21. Sign fure of Fureral Fervice Lice	1500			. Name and Addre	o c	auffer F ke Fred	uneral Homerick, Man	nes, P.A. cyland 21702	2
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. D	o not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	- 3			noma				Onset and Death	
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	ted nsit	nine	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequen	ce of):						
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68760,	icate be executed physician and the burial-transit	Medical B		_d								
99	ertifica ing ph e as th	Med	IF FEMALE:							1		
0	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the first series of the series of	2 ☐ Fetal de	ath 3□	Ectopic pregnanc Other <i>(specify)</i>	y .		23d. Date of de Month	elivery Day Year	
ecords, P.	requires that the peen signed by th hould be detache	ک ا	Part II. Other significant conditions of	contributing to death bu	t not resulting	g in the ur	nderlying cause giv	en in Part I.	23e. Did tob	/	to the cause of death?	า
r	siclan: The law re certificate has be rector, page 2 sho	Completed							24a. Was ar autops perforn	y prior to ned?/ death?		<b>9</b>
	lan: ortifica ctor, p	BeC	25. Was case referred to medical	U				26. Place of Deat			s 2□No	
0	Physiclan: r this certific ral director,	일	examiner? 1 □ Yes 2 □ No	Hospital: 1,□ Inpatie	nt 2 🗆 ER/	Outpatien	t 3 DOA Oth	er: 4  Nursing Ho	ome 5 Reside	ence 6 ☐ Other (Spe	ecify)	
	ng After	ü	27. Manner of Death  1	28a. Date of Injur (Month, Day	y 28t (Year)	o. Time of Injury	28c. Injur Work	ry at	-	w injury occurred		
<u> </u>	Attending or death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not b	a				Yes 2 □ No				
DIVISION	tal or At s after of al Direct ed in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, . <i>(Specify)</i>	farm, stre	eet, factory, office		28f. Location (St. City or Town	reet and Number or F , State)	ural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  Certifying Properties of the control of the cont	nysician: To the best on niner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tire restigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)	
	To the company of the	M	29b. Signature and title of certifier	4 1/	·L		29c. Licens	e number	25	9d. Date signed (Mon	th, Day, Year)	
			Shash	[105]]RU	51		13496	14010		4/19/09	1:50 pm	7
	4		30. Name and address of person who	completed cause of de	eath (Item 23	a) (Type, F	Print)	derick				
	Sta	е	31. Date filed (Month, Day, Year)	32. Registra	s Signature	1 1	11/1/6	enerice !				
	Registra	-	APR 2	3 2009	enera	A.	parker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jacqueline Wandji April **ተ**ሄ,20 ቻ 1446 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5 Month 3 Pay 1 9 3 1 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min Hours Cameroon 1 □ M 2**X** F 57 213-69-1073 **Director** Usual Residence of Decedent 10c. City, Town or Location
Silver Spring 10d. Inside City Limits with the Maryland 10a. State 10b. County r than "natural", or items 23a or 28a-f shov If e Medical Examiner must be notified at 28a-f show Md Montgomery 1 □ Yes 2 No Director 10f. Zip Code 20903 10e Street and Number 10308 New Hampshire Avenue 10g. Citizen of What Country? Cameroon r death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event. It is Marked once. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Black 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing assistant Health Care 17. Father's Name (First, Middle, Last)
David Nzia 18. Mother's Name (First, Middle, Maiden Surname)
Pauline Nana Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7667 Maple Ave. #506 Silver Spring, Md20910 Yves-Paulin W.Mbangue/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 N Removal from State 5/09/2009 Bamena, Cameroon Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) PHIME IN PADO SERVICE, P.A. 21. Signatul Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death Hypoxic respiratory failure Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):
Adult respiratory distress syndrome Examiner Sequentially list conditions, π any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) physician and sthe burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension, diabetes mellitus, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown retroperitoneal lymphadenopathy, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has but director, page 2 sl autopsy perform morbid obesity, liver masses 2 No 1 ☐ Yes 2 🗆 No 1 ⊡Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

ours after death.

Neral Director: A
filled in by the fu completely

To the Hospital within 24 hours a To the Funeral 6

State Registrar

Nejib Siraj 31. Date filed (Month, Day, Year)

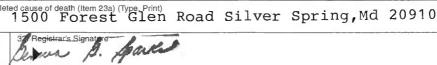
30. Name and address of person who completed

MD

29b. Signature and the of certifier

29a, Certifier

(Check only one)



and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D68150

29d. Date signed (Month, Day, Year)

April 16,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Of State Registrar		ertificate of Death		eg. No. 2009	1483
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Elbert Yates			Apri1	19 2009	6:00 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and nur		4b. City, Town, or Location of Death		4c. County of Death	
			Charlotte Hall Veterans 5. Social Security Number 6. Sex	Home 7. Age (In yrs. last birthday)	Charlotte Hall  of the Hall of	8. Date of Birth	St. Mar	•
	Funeral Director		220-34-3834  Usual Residence of Decedent	80 Yrs.	Months Dave Hours Min	(Month, Day	Year) Cou 4,1929 Nor	pplace (State or Foreign intry) th Carolina
	rland ow ≝		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Mary Ff sh	ţō	Maryland St. Mary's	Char1	otte Hall			1 ☐ Yes 2 ☐ No
	or 282	ired	10e. Street and Number	onar 1	10f. Zip Code	10	0g. Citizen of What Cou	intry?
	th wit	Funeral Director	29449 Charlotte Hall Ro	ad	20622		Unit	ed States
	rdea	nue	Armed Fo	dent Ever in U.S. 13. rces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
3-003p	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire m Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I to Madical Exprising rust be rediffied at once.	d by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ XYes 3 ☐ Widowed 4 ☐ Divorced Year or Di	2 No	1 ☐ Yes 2 📉 No Specify:		Specify: B1a	
i i	n 72 h	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business/li	ndustry
7 7	withi liene. r thar	dmo	Elementary/Secondary (0-12) College (1	-4or 5+)	eel Worker		Fabrica	tion
2	other other	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, M	Maiden Surname)	
yland	And be Antarked rked tic ev	TO B	Kinsey Hayes		Ro	da Yates		
a	and Nama		19a. Informant's Name/Relationship (Type. Print)	T.	ling Address (Street and Number or Ru		•	
e, Mal	and 2 ealth n 27		Peggy Yates/Daughter		l Franklin Road,			
9	les 1		20a. Method of Disposition	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date 2	20c. Location - City or T	own, State
	Pag tment tant: jury		1 ☐ Burial A ☐ Cremation 3 ☐ Removal from 5 ☐ Other (Specify)				Charlotte	
Dallimor	permit Depar Impor any In	l	21. Signature of Fundal Service Ilcensee		22. Name and Address of Facility Ar 211 St. Mary s Ave			
			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do not er	nter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		RRHYTHMIA	Š		Onset and Death
and the same	/Medical Examiner			or as a consequence of):				
	Examiner	_	Sequentially list conditions, b. EN		RENAL DIS	EASE		
	ted nsit	nine	Soque, tially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (	or as a consequence of):				
_6	execu n and al-trar	Examiner	that initiated events c	or as a consequence of):				
00/00,	ysicial buri	call	d					
0	rtifica ng phy as th	<b>l</b> edi						
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	very Day Ye ar
Ļ	s that ined b	by Pł	Part II. Other significant conditions contributing to de		underlying cause given in Part I.	23e. Did tob	bacco use contribute to	the cause of death?
ğ	equire en sig ould b			ITUS		1 □ Ye	es 2 No 3 Pro	obably 4 hknown
necords,	The law re te has be age 2 sho	Completed	ADENOCARCINOM	A OF RI	ECTUM	24a. Was autops	med? prior to c death?	topsy findings available completion of cause of
מ	ian: rrtifica stor, p	Be C	25. Was case referred to medical		26. Place of Dea	1 □ Yes 2 th (Check only on		ZENO
>	hysic his ce I direc	일	examiner? 1 Yes 2 No Hospital: 1 1	npatient 2 - ER/Outpatie	ent 3 DOA Other: Wursing H	ome 5 ☐ Reside	ence 6 Other (Spec	cify)
NISIOII OI	ing P	on:	27. Manner of Death 28a. Date 1 Natural 5 Pending (Monit	of Injury 28b. Time ( th, Day, Year) Injury	Work?	28d. Describe ho	ow injury occurred	
2	ttend death ttor: /	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 288 Place	of laining. At home form a	M 1 Yes 2 No	Of Leastien (Of	turnet and Norman and Di	Pouts Number
$\leq$	or A after Direc in by	Certification:	4 Homicide determined 286. Flace building	of Injury - At home, farm, s ng, etc. <i>(Sp</i> ec <i>ity)</i>	treet, factory, office	City or Town	treet and Number or Ru n, State)	rai Houte Number,
	spital ours neral filled		29a. Certifier 1 Certifying Physician: To the	best of my knowledge, dea	ath occurred at the time, date and place	, and due to the c	ause(s) and manner as	stated.
	he Ho in 24 h he Fur pletely	Medical	(Check only 2 Medical Examiner: On the b		investigation, in my opinion, death occu			
	To t To t	Σ	29b. Signature and title of pertifier	-	29c. License number	2	9d. Date signed (Month	ı, Day, Year)
			Patient S., N	1D	D67788		April 23, 2	2009
7	2 11/1		30. Name and address of person who completed caus			.11 26	1 1 00604	)
D	U LYH		Leena Rao Kodali 29449 C	enistrar's Signature.		all, Mar	yrand 20022	<u>-</u>
	Sta Registr		APR 2 3 2009	news B. 4	barke			

DHMH 17 Rev 1/2001

09-03324 Jeremy L. Yutzy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 14832 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 25, 2009 1730 hrs **Medical Examiner** Jeremy Lynn Yutzy c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Allegany Cumberland Memorial Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Maryland Months Days Hours Feb. 3, 1979 Director 30 159-62-8747 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No s 23a or 28a-f show e notified at once. Frostburg MD Allegany Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at non-10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 這 21502 10009 Piney Mountain Rd. 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Yes 2 X No If Yes, Give Year White Yes 2 X No specify. Specify: Widowed Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 WCI Correctional Officer 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Deborah Yutzy Harold Yutzy, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 10009 Piney Mountain Rd., Frostburg, MD Jennifer Morgan/Companion 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Saltimore, 1 X Burial 2 Cremation 3 Removal from State Emmanuel Methodist Cem. April 29 2009 Frostburg, MD Donation 5 Other Specify: 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee Impor P.O. Box 275, Grantsville, MD 23a. Part I. Int - the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. Li k only one cause on each line Death /Medical a. Torso Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last Physician/Medical g physician a AMENDED UNPENDED The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year attending p Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. è 1 Yes 2 ✓ No 3 Probably 4 Completed s been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed? certificate h ector, page 2 No ✓ Yes 2 Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other<sub>4</sub> Hospital: 1 ✓ Inpatient 2 Residence 6 Other: DOA Nursing Home 5 ER/Outpatient 3 1 ✔ Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury Driver motorcycle involved in collision with auto Certification: Apr 25, 2009 1243 hrs 1 Natural Yes 2 V No Pending Director: d in by the f 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Route 40 & Piney Mountaian Road, Frostburg, MD determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Ľ, 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 27, 2009 O.C.M.E. /Θ 30. Name and address of person who completed cause of death (Item 23a) OCME 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month 1887) 32. Registrar's Signature State b-assert Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 130 A M MAY 2009 EDGAR BOHAN ARGO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Baltimore Saltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Director 1941 Delaware Nov. 222-24-4877 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Exercitive traist be notified at 1 ☐ Yes 2√⊡ No Directo Maryland Phoenix Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21131 USA or items 23a 3612 Sweet Air Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced al Hygiene. I other than "natural", White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Newspaper & Magazine College (1-4or 5+) Elementary/Secondary (0-12) Publication Writer/Cartoonist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h Linda May Enright Edgar Benjamin Argo ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19970of Health 30619 Cedar Neck Rd., Unit 1204, Ocean View, 27 <u>Marlene Argo / Sister</u> Department of Heal Important: If item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 5-6-09 Hilltop Service Corp: 22. Name and Address of Facility
MCComas Funeral Home, P.A. 21. Signature of Funeral Service License 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician troke an disease or condition resulting in death) - /Medical Due to (or as a consequence of): Examiner hemorrhage utvacratial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offs or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Ye ar Month 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe certificate 1 □ Yes 2 No 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 5 ☐ Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and tij 29d. Date signed (Month, Day, Year) RES 000 who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Baltimore

Sinai

32. Registrar's Sign

Fritz, T.D

Heipital

2601 W. Belveder, Baltimac MD 21215

			For Amend State Registrar	Item 3 <sup>St</sup>	ete of d	Marylan <b>1.</b> ,g89	d/ <b>.05/</b> 6	8/09dh rtificate	of He	alth a eath	and Me	ntal Hyg	giene Reg. No.2	2009	1483	L
	Dhoraich		1. Decedent's Name (First, Mi	ddle, Last)							2	. Date of Dea Month	ith Day	Year	3. Time of Death	
	Physicia /Medic		Robert	Наз	rry		Andr					pril 2	7	009	11:40a.	М
1	Examin	er	4a. Facility Name (If not institu		and numb	er)		4b. City, Tov			f Death			ounty of Deat		
west of the			5729 Oaklar	d Road	7	Age (In yrs.	last hirthday	Balti If Under 1 Y		e If Under 2	24 Hrs.   8	. Date of Birt		ltimore	hplace (State or Fore	eian
	Funeral Director		5. Social Security Number 215-09-5311	1 🗓 M 2		91	Yrs.			Hours	Min.	(Month, Da)	y, Year)	Co	untry) land	g.r
			Usual Residence of Decedent			71		L				ug. 0,	1717	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	yland how		10a. State 10b. Cou	nty		10c. Cit	y, Town or Lo	cation							10d, Inside City Lim	
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	ath w		5729 Oakland					212					US		den la diam	
	er de	Funeral	11. Marital Status	Aı	med Force	ent Ever in U. es? □ No.	S.   13.	Was Decedent If Yes, specify	t of Hisp Cuban,	Mexican	gin? (Speci i, Puerto Ri	can, etc.)	12	<ol> <li>Race - Ame Black, White</li> </ol>		
36	rs aft	by F	1 ☐ Never Married 2 ☐ N 3 ☐ XWidowed 4 ☐ Divor	ced If	☑Yes 2  Yes, Give ear or Date	s: WW I]		1 □Yes 2 🔀	No	Specify:			9	Specify: [	SA	
21215-0036	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show died Examinat het rofffed at	ted		dent's Education				dent's Usual C						d of Business	*	
215	within 7; iene. 'than "n he Medi	ple	(Specify only high	T	ollege (1-4	or 5+)	life.	kind of work o DO NOT use r	retired)	ring most	t or working			imore C	•	
21	d wit /gien er th	Completed	12	<u></u>			Lieut	cenant						се Бера	rtment	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I may limportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Madical Examination in at Lean office and Injury or other traumatic event, It alwadical Examination is an once.	Be	17. Father's Name (First, Mide	dle, Last)	٠ ا				1			First, Middle,	Maiden S	iurname)	D	
<u> </u>	should be and Mental marked of umatic ev	ပ္	Harry		Andr	ews	101 11:35				ldred	Doute Numbe	or City or	Town State	Burkman	
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relati					ng Address <i>(S</i> Perfec				Houne Numbia lumbia			zip Code)	
	1 and 2 Health em 27 i	lmi	20a. Method of Disposition	Daugn	LEI)	20b. F		sition (Name matory or othe			Da			ation - City or	Town, State	_
nor	Pages nent of ant: If its ary or o		1 ☑ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe		al from Sta	ate i		matory or othe ck Ceme			5/5/0	0	Ra1+í	imoro	Maryland	
Baltimore,	permit. Pages Department of Important: If ii any Injury or once.	Ш	21. Signature of Funeral Serv			роис		2. Name and A								
B	Depar Impo any Ir	Ų	2					3620 Wi								
	-	2 1	23a. 11. Enter the disease shock, or heart failure.	, or complication	ns that cau	sed the deat	h. Do not en	ter the mode o	of dying,	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between	
ing.	Physician	1	Immediate Cause (Final disease or condition	LIST OTHY OTH OUT	En	d 5/	ue t	kant	F	zi em				1	Onset and Death	
-	/Medical		resulting in death)	a	Due to (or	as a conseq	uence of):	1 4	7 "	•					1111	
es .	Examiner	_	Sequentially list conditions,	b	0	none	my to	kant	03	5.					7	
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10	xecut and II-tran	хап	that initiated events resulting in death) Last	с	Due to (or	as a conseq	_ <u>v</u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,,,,,					7,	
8760,	death certificate be executed in attending physician and id for use as the burial-transit				,											
687	ificate g phys	Physician/Medical		a												
Вох	eath certific attending p for use as	n/M	IF FEMALE: 23b. Was decedent pregnant			me of pregna							2:	3d. Date of de		
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Vital Records,	<b>Physician:</b> The r this certificate ral director, pag	Be	25. Was case referred to med examiner?	lical Hospit	al:				Other			(Check only o				
o	Phys rthis ral die	.To	1 ☐ Yes 2 ☐ No 27. Manne of Death		1 ∐ inp Ba. Date of	Injury	ER/Outpatie	nt 3 DOA	<u> </u>	4 🗆 INC	ursing Hom	Bd. Describe		Other (Sp	ecify)	
on	ding th. Afte fune	tjor	1 Natural 5 ☐ Pe		(Month,	Day, Year)	Injury	М	. Injury : Work? 1 □ Ye	es 2 🗹						
Division	Attending r death. sctor: After by the funer	ifica	3 ☐ Suicide 6 ☐ Co	uld not bo				reet, factory, o	ffice		28	Bf. Location (	Street and	i Number or F	Pural Route Number,	
	al or s after al Dire	Certification: To	4 Homicide		building	, etc. (Speci	<i>1y)</i>					City or To	wn, State)			
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Cert	ifying Physicia	n: To the b	est of my kno	owledge, dea	th occurred at	the time	e, date ar	nd place, a ath occurre	nd due to the	cause(s)	and manner a	as stated. e to the cause(s)	
	To the H within 24 To the F complete	Medical	one)		and manne											
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	Registr		MAYO	0.0000	h		A 160	2 Kel								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:45 P.M 2.009 May 6, Dorothy Hamilton Buell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 19813 Valley Mill Road Freeland er 1 Year | If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2XXF 90 19, 1918 North Carolina 218-05-4976 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 ☐ Yes ŽXNo Director Maryland Baltimore Freeland 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 19813 Valley Mill Road 21053 of America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes ZXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes XXNo Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th C&P Telephone Co Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Bernard Manner Rita Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trainonce. Bonnie G. Schrank (Daughter) 19813 Valley Mill Road, Freeland, Maryland 21053 20b. Place of Disposition (Name of Crest Lawn Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition May 11, XIX Burial 2 ☐ Creme 3 DRemoval from State 2009 4 □ Donation 5 □ Other (Specify) Marriottsville, Maryland 21. Signature of Fur A Beprice License 22 Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock or heart failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest mm diate Cause (Final Physician resulting in death) /Medical Due to (o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examine The law requires that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent premant in the past 12 months? 3 ☐ Ectopic pregnancy Live birth 2 Fetal death in the past 12 mg 1 ☐ Yes 2 ☐ N Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con tute to the cause of death? þ 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes certificate 1□ Yes 2 □ N 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only op Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient ဥ 6 ☐Other (Specify) ours after death.

neral Director: After this
filled in by the funeral di this 27. Munn i D 1 atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? f Death Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician:

within 24 hours a

052 31. Date filed (Month, Day, Year) State

29a. Certifier

29b. Signati

Mb

🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states

29d. Date signed (Month, Day, Year)

Registrar

Medical



	•	For State Registrar	State of Ma	aryland / D		of Health and	d Mental Hyg	_	14836
Physicia /Medic	al		CKEMETE	P	41. 63. T.	Lashing of D	2. Date of Deat Month OS	Day Year 06 2009	3. Time of Death
Funeral Director	er	5. Social Security Number 6. 218-70-6511	Auma C	e (In yrs. last birth	day) If Under 1			Year) C	rthplace (State or Foreign ountry) ARYLAND
e Maryland la-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD CARRO	DLL	10c. City, Town					10d. Inside City Limits 1 □ Yes 2 □ XNo
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If time ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Marical Examinant matter notified an once.	Funeral Director	10e. Street and Number 2027 OLD WESTMI 11. Marital Status	NSTER PIKE  12. Was Decedent Armed Forces?	Ever in U.S.		048	? (Specify Yes or No- uerto Rican, etc.)	0g. Citizen of What C  USA  14. Race - Am Black, Whi	erican Indian,
2 hours after natural", or it	ģ	1 ☐ Never Married ★★ Married 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's I (Specify only highest of	1  Yes 2 ☐ If Yes, Give Year or Dates:	No 16a. I	1 ∐Yes 2 🔀 Decedent's Usual O	[No Specify:		Specify:	WHITE
filed within 7 al Hygiene. other than "rent, in Med	Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las	College (1-4or 5 + YEARS	5+)	OGRAM COC	etired) PROINATOR_	Name (First, Middle, I	COURT	CO. CIRCUIT
Vical y land	To B	WILLIAM R. WINN  19a. Informant's Name/Relationship	(Type. Print)		•	reet and Number of		r, City or Town, State,	
Pages 1 and ment of Health ant; If item 27 ury or other th		LEWIS BERKEMEIER  20a. Method of Disposition  1 N Burial 2 Cremation 3  4 Donation 5 Other (Spec	Removal from State	20b. Place of E cemetery,	Disposition (Name of crematory or other  Disposition (Name of crematory or other  DD CEMETE			INKSBURG, 20c. Location - City of BALTIMORE	r Town, State
permit. Pag Department Important: I any injury o	1 1	21. Signature of Funeral Aervice Lichard  23. Part 1. Enter the disease, or coshock, or heart failure. List on	4-Vaus	m	8521 LC	ddress of Facility  CH_RAVEN  f dying, such as car	BLVD. TO	WSON, MD	HOME, P.A. 21286 Approximate Interval Between
Physician /Medical Examiner	6 7	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. DRAIN  Due to (or as	a consequence of	): [[0 N				Onset and Death
te be executed ysician and e burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of		Theo	din U. K	MEDICA DEXAMINE	dr.
the death certificate by the attending physiciched for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 🗌 Fetal death	3 ☐ Ectopic preg 5 ☐ Other (speci			23d. Date of do	elivery Day Year
w requires that the de been signed by the should be detached to	by	Part II. Other significant conditions PELVIC FRACE		ut not resulting in t	he underlying caus	e given in Part I.	23e. Did to		to the cause of death?  Probably 4 Unknown
an: The law tificate has b tor, page 2 sl	Be Completed	25. Was case referred to medical				26. Place of	24a. Was a autops perfore 1 □Yes	prior to death? 2 2 No 1 □ Ye	
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To B	examiner?  27. Manner of Death  1  Natural 5  Pending 2  Accident investigati 3  Suicide 6  Could not 4  Homicide	28a. Date of Inju (Month, Da	ury - At home, farm c. (Specify)	me of ury P M 28c.	Injury at Work? 1 □ Yes 2 Ø No	28d. Describe ho	treet and Number or F	ind Shield
he Hospital in 24 hours he Funeral ipletely filled	Medical C		Physician: To the best aminer: On the basis of and manner st	of my knowledge, of examination and			lace, and due to the o	cause(s) and manner	ON TYTO as stated.
To t	Σ	29b. Signature and title of certifier  30. Name and address of person wh		leath (Itam 22a) /T	P	20778		9d. Date signed (Mor	009
Star Registra		ANTON CLEOPEU  31. Date filed (Month, Day, Year)  MAY 08	(€V D.O 2009 32. R gistr	ar's Signature	Sar	uC 35	S. BREE	N STR. BALL	TRUPE, HD 212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 10e, f per fh g891 5-8-09 vt
State of Maryland / Department of Health and Mental Hygiene 2 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year William Daniel Brennan 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata 8. Date of Birth
(Month, Day, Year)
Tuly 30, 1947 f Under 24 Hrs. 5. Social Security Number 1 Year Birthplace (State or Foreign Country)
 New Jersey Age (In yrs. last birthday) **Funeral** Months Davs Hours Min 1**∑** X 2 ☐ F 220-50-3518 61 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a State 28a-f show 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Rosedale 1 □Yes 2√No 10e. Street and Number 10f Zin Code 1748 10g. Citizen of What Country? Chesaco Ave. ō 21237 3012 Northbrook 23a USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒️№0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0036 5 white If Yes, Give Year or Dates: 1 ∐Yes 2√25No Specify: 2 Specify 3 ☐ Widowed 4XXDivorced Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4or 5+) Elementary/Secondary (0-12) University Of Maryland Corporate Contract Adminst. 12 traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Charles Brennan Johanna Blake ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health a Timothy Brennan-son 3012 Northbrook Road-Baltimore Maryland 21209 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery May 9,2009 Parkville, Maryland 4 □ Donation 5 □ Other (Specify) permit. 8800 Harford Road Parkville,MD 21234 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LME CHAPEL SERVICES ordal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed のx 68760,公 that initiated events resulting in death) Last Due to (or a a consequence attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 ☐Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2\* ⊠No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA this Certification: To thours after death.

uneral Director: After this by filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 **⊠**Natural Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled is To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) 0 of person who completed cause of death (Item 23a) (Type, Print) and address 31. Date filed (Month, Day, State 32. Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH. G891.5/20/09 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 4 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 Year Day **Physician** 5:10 P.M Carolyn T. Bonnett May 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice TOWSON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. . 699 Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours Min. Months 62 Yrs. <del>19-</del>46-6560 1 □ M 2√2₹ 11/1/1946 Missouri Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Event was a nat be notified at Perry Hall 1 ☐ Yes 2 No Maryland Baltimore Director 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21128 5409 Bobby Joseph Court of America Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7½ th and Mental Hygiene. ?**7 is marked other than** "na College (1-4or 5+) Elementary/Secondary (0-12) Lobbyist Lobbyist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevieve Vinyard Roger H. Taylor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar 5409 Bobby Joseph Court Perry Hall, Maryland Mrs. Alice K. Davis/ daughter 20b. Place of Disposition (Name of cemetery, crematory ozother place)
LVAIIS Furieral Air 20c. Location - City or Town, State May 8, 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any Injury or otf 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service 10/2to. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SAUAMOUS INS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine any, leaving to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) Ö certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 Unknown 1 □ Yes 2 📆 🔊 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 □Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 6 Other (Specify) WSDU 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N' Charles State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** May 2009 11:20 ₩ CAROL D. BROOKS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 1651 E. BELVEDERE AVENUE APT 414 N/A5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. 50 MAY 30 1958 MARYLAND Director 217-68-1504 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. XXYes 2 No Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1651 E. BELVEDERE AVENUE 21239 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2XXNo Specify Specify: BLACK <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE <u>2yrs</u> HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK GRAVES ပ RUTH YOUNG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1651 E. Belvedere Ave. Apt 414, Balto. Md 21239 Carol D. Brooks/Self Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) LOUDON PARK CEMETERY: 05-08-09 BALTIMORE, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Mour 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 01.000 CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 6 month DISEASE METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical 687 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) the o 9 Unknown 9 🗀 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medicel Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier ca (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D22652 MD. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. S. SRINIVAS 5601 LOCH PAVEN BLVD BALTIMORE 21239 31. Date filed (Month, Day, Year) MAY 0 8 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ Certificate of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** М /Medical Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Year) 1956 Hours Min. 1 □ M 2/OXF h, Day, SOUTH CAROLINA 53 Yrs JAN Director 203-46-0606 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show nust be notified at 1X Yes 2 No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò Pages 1 and 2 should be filed within 72 hours after death with U.S.A. items 23a 2236 RUSKIN AVE. 21217 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ANo 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 P, 1 ☐ Yes 2 🛛 No Specify. þ Specify: 3 Widowed 4 Divorced BLACK 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical marked other than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. NURSING HOMES HOUSEKEEPER llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ CHARLES WATTS MARY WATTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trauonce. Baltimore, Maryland 21217 George Branch/Husband 2236 Ruskin Ave., 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State LANSDOWNE, MARYLAND 05-13-09 ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 5 Other (specify) 1 ☐Yes signed by the a 9 Unknown 9 Unkno 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 Ho 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ♣No 24a. Was an autopsy 1 □Yes 2 this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral of Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No deaith. hours a er death.

uneral Director: /
ly filled in by the fi 6 □ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours a

To the Funeral Di

completely filled To the Hospital

> State Registrar

and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Michael Brown Ray 2009 0720 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year If Under 24 Hrs. Samarita to50, ta 8. Date of Birth (Month, Day, 8-29 Birthplace (State or Foreign Country) 7. Age (Ih yrs. last birthday) 5. Social Security Number 6. Sex -1956 **Funeral** Months Days Hours 1**∑**M 2□ F 215-68-Yrs. MD 52 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County item 27 is marked other then "neturel", or Items 23a or 28e-1 show other treumatic event, It a Nedical Examinar must be inclined 1X Yes 2 No Director N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21239 1344 Stonewood Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married USA 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withing the filed with best of Health and Mental Hygiene. 12th grade Unemployed Unemployed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဂ္ Dorothy Hancock Willie Ray Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10606 Bunclody Drive Charlotte, N.C. 28213 permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree Deborah Brown -Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5-8-2009 Balto, MD Mt Carmel Cem \* 4 ☐ Donation 5 ☐ Øther (Specify) March East F/H 21. Signature of Fundal Service License 22. Name and Address of Facility Balto, MD 21202 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician inknows disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Division of Vital Records, or Attending Physicien: Be Medical Certification: To in by the funeral after death.

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

Hospital: 1 Inpatient 2 R/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

28a. Date of Injury (Month, Day Year) 1 Datural 5 Pending investigation 2 Accident 6 ☐ Could not be

determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy

2X No

29a. Certifier

3 Suicide

4 Homicide

\*\*Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title/of certifier

MAY 08 2009

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a
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completely filled

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02893 State of Maryland / Department of Health and Mental Hygiene 14842 Karen Bradshaw-Phillips Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 11, 2009 0314 hrs Medical Examiner BRADSHAW-PHILLIPS KAREN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center Date of Birth (MM/DD/YYYY)Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours NORTH CAROLINA JULY 21 1963 Director 1 M 2 X F 45 Yrs 238-23-1657 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Į, 1 X Yes 2 No UPPER MARLBORO 23a or 28a-f show notified at once. PRINCE GEORGE'S MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20774 14501 THORPE LANE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married be filed within 72 hours after death NoARMY 1X Yes ö Specify: Yes, Give Year or Dates: Yes 2 No specify: BLACK Divorced Widowed Examiner ρ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) dunng most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) marked other than " Pages 1 and 2 should be filed within 12 ment of Health and Mental Hygiene. GOVERNMENT NURSE 21215-0036 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DORIS JOHNSON Be BRADSHAW SR <u>JAMES R.</u> (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) Important: If item 27 is m injury or other traumatic THORPE LAME UPPER MARLBORO, MARYLAND 20774 CARLTON A. PHILLIPS/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 3altimore, Burial 2 X Cremation 3 Removal from State RIVERDALE, MARYLAND 5/5/2009 RIVERDALE CREMATORY **Jepartment** Donation 5 Other Specify: JENKINS FUNERAL HOME 22. Name and Address of Facility J. B. 21. Signature of Funeral Service Licensee ROAD LANDOVER, MARYLAND 7474 LANDOVER 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and Death **Tedical** Cardiac arrythmia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Cardiomyopathy Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed PI line a-b, 2/,perME, g892 6/4/09 TT sician/Medical X UNPENDED by the attending physician sched for use as the burial 23d. Date of delivery 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 Box ( 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? 된 contributing to death but not resulting in the underlying cause given in Part I. signed by the detache <u>о</u> Yes 2 No 3 Probably 4 V Unknown þ Completed 24b. Were autopsy findings available 24a. Was an Records, been prior to completion of cause of autopsy performed? death? No No 1 🗸 Yes 2 ✓ Yes 2 page After this certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: Residence 6 Nursing Home 5 DOA Inpatient 2 Y ER/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: X Natural Yes 2 Director: Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) Suicide Funeral D determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) L<sub>o</sub> 29c. License number 29b. Signature and title of certifier April 11, 2009 O.C.M.E.

Registrar

**OCME 2006** 

State

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) Date of Birth (Month, Day, 7. Age (In yrs. ast birthday) **Funeral** Min. 1 M 2 K Months **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Everning must be notified at once. 1 es 2 No Director 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ nterance Administrator 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other Burial 2 Cremation 3 Removal from State 21. Signat re Funeral S rvice Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 ☐ Unknown 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) P.0. been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes → 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛋 1 🔲 Inpatient ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Funeral Director: After upletely filled in by the funeral Division To the Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) (UCi) Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:59 PM May 4, 2009 Kathleen Patricia Bulmash /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center At GBMC Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Date of Birth (Month, Day, Months Days Hours 1 □ M 2 X F Maryland May 6, 1948 Director 215-50-8215 60 Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits show 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3264 Dublin Road 21154 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 21 No Specify 2 Specify: 3 ☐ Widowed 4 ☐ Divorced ed other than "natural", event, it a Madical Exa White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed wellealth and Mental Hygier am 27 is marked other the Social Services Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbur Crawford Ober Elizabeth Patricia Hussey ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Gerald Bulmash / Husband 3264 Dublin Road, Street, Maryland, 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of h Important: If ite any Injury or ot Injury or ( 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/9/2009 Trinity Lutheran Cem. Joppa, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) ourc renc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Orderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending properties of the second se IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 □ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☐ No Division of Vital director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Dother (Specify 100) 1 ☐ Yes 2 ☐ **6**0 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? Hospital or Attending 5 Pending ue Funeral Director: A pletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely 1 (2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24

29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

NOUNG

09-03071	
Donna Baker	

nna Baker		- For State	ite of Maryla		ment of ficate of		and	Menta	l Hygi		Reg. No.	20	09 11	484
Physicia	n/	Registrar 1. Decedent's Name (First, Middle	,Last)							Date of Dea Month	Day	Year	3. Time of Deat 0936 hrs	h
dical Examir		Donna Baker				-		P 4 F	A	April 17, 1	2009	c. County of Dear		
		4a. Facility Name (if not institution 820 S. Caton Avenue A	-	mber)	4	b. City, Tow Baltimo		cation of L	Jeam			o. County of Boo		
Eurosol		5. Social Security Numberink		7. Age (In yrs. last	birthday)	If Under		If Under 2	24Hrs.   8	B. Date of B	irth(MM	/DD/YYYY) 9. B	rthplace (State or	
Funeral Director			1_M 2XF	46		Months	Days	Hours	Min.	July	10,	1962 Fore	ign ountry)Mary1	and
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212 buld be Menta mark ic even	e e	19a. Informant's Name/Relations			19b. Mailing	Address	(Street					City or Town, Sta	ite, Zip Code)	
MD d 2 sho tth and n 27 is		Mildred Scurt	o/mother									burg, VA		
re, l	Ī	20a. Method of Disposition  1 Burial 2 Cremation	3 Removal f		ace of Dispos ematory or oth		of cem	etery,	[	Date	20c	. Location - City	or Town, State	
Pages nent of		4 Donation 5 X Other Sp												
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Wage.	Director	St	ate Ai	ddress on a to	my Bo	pard	655 1	W. B	altimor	e Street	
		23a. Part I. Enter the disease, or	complications that	caused the death. I	Ba Do not enter the	ltimo ne mode of	re, dying, s	MD 2 uch as car	2120 rdiac or r	espiratory a	arrest, si	hock, or heart	Approximate	
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xaminer		Immediate Cause (Final disease or condition resulting in death)		a consequence of)		SCICI	.001	c car	<u>u rov</u>	ubcu1	·u·	<u>u rocuso</u>		
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cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	dical	X UNPENDED	AMENDED	23a,2/,p	erME,	g892	6/1	9/09	TT					
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30X death e atte	ysic	1 Yes 2 No 9 🗸 Un		nown	3 0	mer (opec	"y/							
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of Vital Records, ling Physician: The law require.  Ander this certificate has been si funeral director, page 2 should b.	ို	1 Yes 2 No 27. Manner of Death		Inpatient 2te of Injury	ER/Outpatien 28b. Time of		JA	y at Work		Home 5		injury occurred	trier. Scene	
n of rding Pl h. After funeral	on:	1 V Natural	ding (Mor	nth, Day,Year)	200. 11110 01	,		'es 2				, ,		
Division tall or Attending a safter death.  The Director: I led in by the fu	icat	2 Accident Inve	stigation 28e Pla	ace of Injury - At ho	me, farm, stre	et, factory,	office b	uilding, etc	c. 2				Rural Route Nur	nber, City
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:		Id not be ermined (Specif	y)						or low	n, State	)		
Division of Vital the Hospital or Attending Physician: him 24 hours after detect. After this certil repletely filled in by the funeral director.		29a. Certifier 1 Certifying P	hysician: To the basi	est of my knowledg	ge, death occu	irred at the	time, da	ite and pla	ice, and o	due to the o	ause(s)	and manner as	stated.	
To the Hos within 24 h To the Fun completely	Medical	- 124	and manner	r stated.	id/or investiga			e number					(Month, Day, Year	•)
	2	29b. Signature and title of certifi	1	r Ý		250	O.C.I					pril 18, 2009		
		30. Name and address of person	n who completed ca	ause of death (Item	23a)									
		Margarita Korell MD.		edical Examin		Penn Str	eet, B	altimore	e, MD 2	21201				
	tate	HIRV II U	2000	Registrar's Signa	bay	del.								
Regis	trar	MAYUS	LUUY Ale	wa p.	7 wo									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03044 State of Maryland / Department of Health and Mental Hygiene John Michael Burik Certificate of Death Reg. No 1- For State 2. Date of Death Registrar

1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 16, 2009 1100 hrs ' Examiner John Michael Burik Med<sup>3</sup> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown 1101 Dual Highway If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or unk 7. Age (In yrs. last birthday) 5. Social Security Number unk 6. Sex Foreign Funera Months Days Hours Country) Director 1 X M 2 56 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Hagerstown Washington MD s 23a or 28a-f show e notified at once. IMOFE, MD 21215-0036
repages 1 and 2 should be filed within 72 hours after death with the Maryland
repages 1 and Alental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10g, Citizen of What Country? Director 10f, Zip Code 10e. Street and Number 21740 USA 13108 Resh Road 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or Noiink Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Married Never Married Yes No Specify: white Yes 2X No specify: f Yes, Give Year 4 Divorced Widowed 16b. Kind of Business/Industry 2 16a. Decedent's Usual Occupation (Give kind of work done unk unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) unk iink event, the Medical 18.Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, MD O.C.M.E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) Baltimore, other t Removal from State Burial 2 Cremation 3 Donation 5 X Other Specify: in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signatur uner envice Licensee Director Reltimore MD 21201

art I. Enter the discusse, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician fa re. List only one cause on each line. Death **ledical** a. Gastrointestinal Hemorrhage Immediate Cause (Final disease amine or condition resulting in death) Due to (or as a consequence of): b. Chronic Alcoholism Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and trans. sician/Medical AMENDED tending physician a UNPENDED 23d. Date of delivery The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 V No 3 Probably 4 Unknown <u>م</u> Diabetes Mellitus ۵ 24b. Were autopsy findings available 24a Was an Completed Records, s been s prior to completion of cause of autopsy death? performed' No has ✓ Yes Yes 2 certificate h 26, Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: director Residence 6 V Other: Scene Division of Vital Be Other; Hospital: 1 Nursing Home 5 Inpatient ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred ۵ 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification: Yes 2 1 V Natural Pending death. 28f. Location (Street and Number or Rural Route Number, City Director: 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide within 24 hours at To the Funeral D determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 17, 2009 O.C.M.E Le Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

31. Date filed (Month, Day, Year)

ORIGINAL

\$2. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Randalstown MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(rail)

MAY 08 2009

31. Date filed (Month, Day, Year)

oldlowt

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14848 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 2009 Anne Talbot Brennan 7:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14204 Sawmill Ct. Phoenix Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 18, 9. Birthplace (State or Foreign , 1958 1 □ M 2 🕅 F Months Days Hours Min. Maryland 216-80-5583 50 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14204 Sawmill Ct. 21131 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify. 3 Widowed 4 Divorced Year or Dates: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) attorney legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glenn Hardy Helen Ann Welsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Brennan/husband 14204 Sawmill Ct. Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gard May 7,2009 Timonium, Maryland tchell-Wiedefeld Funeral Home, Inc. Raltimore, MD 21212 21. Signature of Funeral Service Licenses John O. Mitchell 6500 York Rd. Approximate Interval Between Onset and Death 23a. Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLORECTAL CANCER VEARS Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe med? 2 No 1 ☐ Yes 1 ☐Yes 2 ☐No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

show

death with the

within 72 hours after

feath and Mental Hygiene.

n 27 is marked other than "n st traumatic event."

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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and burial-trai attending physiclan for use as the buria the ģ signed I has page 2 s certificate this

Box 68760.

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Division of Vital Records,

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law requires that the death certificate be executed Hospital or Attending Physician: The death. after death

Director: A

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completely To the I within 2 State

Sequentially list conditions, if any, leading to immediate cause. It is carry in ground that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number 00062100 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 ORLEAMS STREET

ROOM 407 BALTIMORE, MARYLAND 21231

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAY 0 8 2009

32 Aegistrar's Signature Barks

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Math 730 M **Physician** Michael David Barnycz /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Seasons Hospice @ North West Randallstown 8. Date of Birth NOV22, 1955 5. Social Security Number Sex 14 M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Hours Months Mary land 53 220-64-3271 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show d 2 should be filed within 72 hours after death with the Marylai th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exyminar must be notified at 1 Yes 2 No Director Md. Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 U.S.A. 11 North Linwood Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Leona Sherman Michael Barnycz ဂ္ 19a. Informant's Name/Relationship (Type. Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. North Linwood Avenue Baltimore, Md.21224 Brenda Feathers-Barnycz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem 5-7-2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RMINA UNG CANC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the buriat-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1/Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 King Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Avenue Sule 203

11,250

:	Physician
	/Medica
	Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mudical Evanimating the notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

10 V Stat

	1 = For State Registrar	•	Cer	tificate of E	Death	R	eg. No.	14000				
ian	Decedent's Name (First, Middle, Last)     SARA HUGHES LONG	BODIE				2. Date of Deat Month	Dav Year	3. Time of Death				
cal	4a. Facility Name (If not institution, give street and nu			4b. City, Town, or	Location of Death	May	7, 2009 4c. County of Dea	12:15A M				
ner	Gilchrist Hospice Care	1115017		Towson			Baltimo	re				
	5. Social Security Number 214-30-3249 6. Sex 1 ☐ M XX F	7. Age (In yrs. las	t birthday) _ Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 2	, 1930 Pe	thplace (State or Foreign ountry) nnsylvania				
To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Town or Loc	ation				10d. Inside City Limits				
ctor	Maryland None	Balt	imore					XXYes 2 No				
Funeral Director	10e. Street and Number 4411 Atwick Road			10f. Zip Code 21210		1	0g. Citizen of What Co USA	ountry?				
by	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 FYes, G Year or D	ve		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes XX No Specify:  14. Race - American Indian, Black, White, etc.  Specify: White								
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (		16a. Deced (Give I life. D	ent's Usual Occupa kind of work done d OO NOT use retired,	ation luring most of work )	ing	16b. Kind of Business					
Com	2	1 101 01)		Secretary	_		Manufac	cturing				
To Be	John Baker Roach Long					abb Hugh	nes					
	19a. Informant's Name/Relationship (Type. Print) Carolyn B 0'Keefe	DTR	19b. Mailin 3 St	g Address <i>(Street &amp;</i> <b>Martins</b> F	and Number or Rur Road Balt	imore, Number	r, City or Town, State, Maryland 21	Zip Code) 1218				
	20a. Method of Disposition  X	cem	etery, crem ey Vall	ey Mem Gard	ens May 9	, 2009	Timonium,	Maryland				
	21 Signature of Funeral Service Licensee 22. Name and Address of FaMitchell-Wiedefeld Funeral Home Inc.  6500 York Road Baltimore, Maryland 21212  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
<b>'</b>	shock, or heart failure. List only one cause on	caused the death. each line. ration Pi			g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death 4 days				
	resulting in death)  Due to  Meta	(or as a consequer	nce of):					2 Years				
Examiner												
Medical Exa												
Physician/Med	230 If you guttome of programmy											
Š	Part II. Other significant conditions contributing to o	leath but not resulti	ng in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute t es 2 <b>XX</b> Io 3□ F	to the cause of death?  Probably 4 🗆 Unknown				
completed				<u>.</u>		24a. Was a autops perfor 1 □Yes						
Be	25. Was case referred to medical examiner?  Hospital:			Othe	26. Place of Deat			Hospico				
tion: To	27. Manner of Death 1 X Natural 5 □ Pending (More	Inpatient 2 ☐ EF of Injury oth, Day, Year)	R/Outpatien 8b. Time of Injury	28c. Injury Work			ence 6 Other (Sp.	ecify) HUSPICE				
Certification:	3 Suicide 6 Could not be 28e. Place	e of Injury - At home ling, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,				
edical C	29a. Certifier (Check only one)  11 Certifying Physician: To the Cone Medical Examiner: On the and mar	e best of my knowled basis of examination	edge, death n and/or inv	occurred at the ting estigation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time, o	cause(s) and manner adate and place, and du	as stated. ue to the cause(s)				
Me	29b. Signature and 地 efficier	Com	ne	29c. License D4212		2	May 7, 20					
	30. Name and address of person who completed cau William D McConnell N				Street B	altimore	e, Maryland	21212				
ate rar		Registrar's Signatur										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 14851 09-03618 State of Maryland / Department of Health and Mental Hygiene Patricia Ann Borowski Certificate of Death 1- For State Reg. No Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1656 hrs May 5, 2009 Borowski Patricia Ann Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Middle River 107 Trailway Road If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Hours Months Davs Mar13 Marvland Director 215-50-7666 M 2 X F 50 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2X XNo Middle River s 23a or 28a-f show e notified at once. Baltimore Md. with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21220 107 Trailway Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Yes Specify: White è 1 Yes 2 X No specify: If Yes, Give Year 4 XDivorced "natural". ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) permit. Pages I and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "-injury or other traumatic even." during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Verizon Telephone Operator 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha E. Fisher Joseph J. Borowski, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Juneway Lane Berlin, Maryland 21811 Isabel Conley-Waters 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition crematory or other place) Removal from State Burial 2 X Cremation 3 Bayview Crematory | 5-8-2009 | Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signa of For eral Service Licensee Md.21222 1201 Dundalk Avenue Baltimore, Part I. Enter the disease, occor pinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only ope cause on each line Death 'V dical Tramadol intoxication Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last pue AMENDED 23a, 27, 28a-f, perME, g891 5/21/09 TT Physician/Medical ysician a X UNPENDED the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If ves. outcome of pregnancy attending phys for use as the b IF FFMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death use 5 Other (Specify) 1 Yes 2 No 9 V Unknown signed by the atte be detached for u g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 Unknown \$ 24b. Were autopsy findings available Completed 24a. Was an Records, ficate has been si page 2 should b prior to completion of cause of autopsy death? performed Yes 2 ✔ No Yes certificate 26.Place of Death (Check only one) hours after death.

neral Director: After this certific
y filled in by the funeral director, J 25 Was case referred to medica Division of Vital Be Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: DOA ER/Outpatient 3 Inpatient 2 1 Yes 28d. Describe how injury occurred subject intentionally overdosed 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Yes 2X No Certification: prescription medication Natural Fd 4:50 pm Pending Fd 5/5/09 28f. Location (Street and Number or Rural Route Number, City or Town, State) 107 Trailway Rd Middle River, MD Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 X Suicide determined (Specify) residence within 24 hours a To the Funeral I 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 6, 2009 O.C.M.E.

who completed cause of death (Item 23a)

Assistant Medical Examiner

distrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

e and address of persor

Melissa Brassell, MD

31. Date filed (Month)

DHMH 17 Rev 1/2001

OCME

State Registrar

			For State Registrar	State of Marylan		artment of H rtificate of L				09 14852	
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Joan A. Charva					2. Date of Dea Month		Year 630A M	
Section of the second	Examin		4a. Facility Name (If not institution, give s Seasons Hospice -I	N.W. Hospital			dallsto	wn		Baltimore	
	Funeral Director		5. Social Security Number 217-38-2544  Usual Residence of Decedent	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		1941	9. Birthplace (State or Foreign Country) Maryland	
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show of cal Examiner must be notified at	Funeral Director	10a. State 10b. County  Maryland N/A  10e. Street and Number  4406 Willshire Ave	enue  12. Was Decedent Ever in U. Armed Forces?		Baltimore 10f. Zip Code	21206 ispanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	U.S.A	-	
1212 Du	/ithin ne. han ⁴	Be Completed by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	e completed) College (1-4or 5+)	16a. Dece (Give life.	1 □Yes 2 ☒ No  dent's Usual Occupa kind of work done of DO NOT use retired  St Office	furing most of w	vorking lame (First, Middle,	Banking	Kind of Business/Industry  nking Industry	
ary	should and Mer is marke aumatic	<b>To</b>	Franklin C. Eyring 19a. Informant's Name/Relationship (Ty, Mrs. Margaret Feeh	/pe. Print)	1	ng Address (Street a	and Number or	ia C. Sk Rural Route Numbe Sysksyill	er, City or Town, S	State, Zip Code) land 21784	
w	permit. Pages 1 and 2 Department of Health Important: If Item 27 any Injury or other tr.		20a. Method of Disposition  1 Burial 2 Cremation 3 H  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Library	Removal from State Mea	Place of Disponentery, crei	osition (Name of matory or other place	e) Park: 05	Date 5-07-2009 530	Elkrid Elkrid	City or Town, State  ge, Maryland	
00,	Physician /Medical Examiner and physician and physician and the prival-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ilications that caused the deather cause on each line.  a. TERMINATION Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):			liac or respiratory ar	rest,	Approximate Interval Between Onset and Death	
O. BOX 6	death certifi e attending p td for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	death 3	☐ Ectopic pregnance	у	23d. Date of delivery  Month Day Year			
	e law requires that the has been signed by th e 2 should be detache	Completed by Pi	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	inderlying cause give	en in Part I.	1 <b>X</b> 2 Y	res 2 □ No	ibute to the cause of death?  3 Probably 4 Unknown  Vere autopsy findings available rior to completion of cause of eath?	
r Vital F	ysician: The nis certificate director, pag	To Be Cor	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1	ER/Outpatie	nt 3 ☐ DOA Oth		1 □ Yes  Death (Check only on g Home 5 □ Resid	2 ∰No   1 ne)	The 2 I to 2016	
DIVISION OF	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification:	27. Manner of Death  1 M Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At hubuilding, etc. (Specification)	28b. Time of Injury ome, farm, st	M 1 🗆	y at ⟨? Yes 2 □ No		now injury occurre Street and Number vn, State)	er or Rural Route Number,	
	the Hospita hin 24 hours the Funera hpletely fille	Medical C	(Check only 2 Medical Exami	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, dea ation and/or i	nvestigation, in my o	pinion, death o	ccurred at the time,	date and place, a	and due to the cause(s)	
	vith To 1	₹	29b. Signature and title of certifier	Burton		29c. Licens	131		May 4	th 2009	
	Sta	ite_	30. Name and address of person who con Pr. Poble Bw. 31. Date filed (Month, Day, Year)	283S 32 Registrar's Signa	Smith	Avenue 8	rule 20	13 Baltin	ware MI	0 21208	
	Registr	ar	WAY N S 200	0 /2	II MA	W. Kar					

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**O**RIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 6:35 a M WOODROW WILSON CASELL JR. May Δ 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE 3023 WALBROOK AVENUE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F 72 Yrs. Director 212-34-7512 JUNE 27 1936 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 1K Yes 2 □ No event, the Medical Examiner must be notified Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō U.S.A. 23a 21216 3023 WALBROOK AVENUE Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married Maryland 21215-0036 ō If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify. Specify: BLACK Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ... wental Hygiene. 127 Is marked other than "r r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) UNIVERSITY HOSPITAL CUSTODIAN unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Mental ANNA R. MILES ٩ WOODROW W. CASSELL SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and De artment of Health Important; If item 27 any injury or other truents 3023 WALBROOK AVENUE, BALTO.MD 21216 Geraldine Cassell/Wife Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial ZXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 105-09-09 METRO CREMATORY 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. kouri 1206 W NORTH AVENUE 23a. Part 1. Elect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** lancer LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): physician use as IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. the 1 Tyes 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. s been signe should be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? The law certificate has page 2 autopsy perform 2 1 No 1 □Yes 2 □No 1 □ Yes Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after filled in within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Rajapalneno 70057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.S. Ray uparts MO 28 Main St., Suite 200, Reisterstown, MD. 21136 N.S. Rajupatte mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Backer Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 11.12 PM Runette Davis 2009 an /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 1 □ M 2√F Davs 578-66-1802 61 Director 4-7-1948 S.C. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be invitined at 1√Yes 2 No Director MD Baltimore N/A 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral 2017 Jubilee 21214 Α 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Chief ofConstituent Serv 12th grade 2 years Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Davis, Sr Elreda Clark ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vonda Clark-Daughter Jubilee Ct Balto, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Øther (Specify) 5-12-2009 Balto, Redemptorist 21. Signature of Fundal Service Linenger 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Imall bowel obstructor 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). aftending physician for use as the buria the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant in the past 12 pronths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No belt ension old 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2. No of Vital 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 / Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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DAVIS

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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istrar's Signature

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State Registrar 31. Date filed (Month, Day

32.

ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year MARY DAVIS 04:40 AM MAY 0 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOPKINSHOSFITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Date of Birth (Month, Pay, Funeral Months Days Hours Min 1 □ M 2 F Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
is marked other than "natural" or Items 23a or 28a-4 show 10c. City, Town or Location

Raltinore 10a. State 10b. County 10d. Inside City Limits 'natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. BlackCompleted by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10+6 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21218 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mae Kalto. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) C. Greene Funeral Serv Name and Address of Facility 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Bicedino Immediate Cause (Final longue **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cancer 4 years Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy 1 ☐ Yes 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2. ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Julia Bland, MEDICAL DOCTOR MAY, 02, 2009

State Registrar

P

Julia Beaver 31. Date filed (Month, Day, Year)

MAY 08 2009

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Julia Beaver, Johns Hopkins Hospital, 600 North Wolfe Street,

2. Registrar's Signature

RES-000

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 200 /Medical 4c. County of Death Facility Name (If not institution, give street and number, or Location of Death Examiner 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Number **Funeral** Days Months Min 1□ M 2 F Yrs. 6 **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Baltimore ral", or items 23a or 28a-f sh Evanting must be notified MDDirector 10g. Citizen of What Country? 10e. Street and Numb 21223 lask Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Blac Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Compge (1-4or 5+) Elementary/Secondary (0-12) other traumatic event, 18. Mother's Name (First Middle, Maiden Surname) ather's Name (First, Middle, Last) Be Boozer HsKer ean 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name Relationship (Type, Print permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau armen Baltimore, Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bicens Nat'I Balte. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory rest, shock, or he in failure. List only one grouse on each filine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical nce of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed fler death. P.O. Box 68760, 2 Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 2 🗌 No 3 Probably 4 → Finknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 L 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | DN 12 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □ No To the Hospital or Atterdi within 24 hours after death. To the Funeral Director A completely filled in by the fu 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 2009 Davenpart /Medical atricia 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Country) Season 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Year 1 □ M 2 🗷 F 243.64.6337 Yrs Director 1940 26 8 Usual Residence of Decedent County 10d. Inside City Limits 10a. State City, Town or Location 10b. 10c 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural". or item any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□Yes 2☑No If Yes, Give Year or Dates: Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be Willie sie Drue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Kussell 310 Davenoor 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State Owing Mills 05-de-01 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vous 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) - Knanic COBSTAUGHT 1V4 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last me Examiner Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical phys the L ding p IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ned by the a o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown AODM 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an 66102 autopsy performed? 1 ☐Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 2 ER/Outpatient Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 6 ☐Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide filled in I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O 丁 5310 Ruca 01 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 08 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10e per A.B. 9895 State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar amend 17 per A.B. g891 5/8/99 ficate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician March 2009 Dylan Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) 9. Birthplace (Ste Country) March 3, 2009 Maryland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 X M 2 □ F Director infant Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2√ No MD Baltimore Director Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e, Street and Number 3458 Barkley Woods Rd Examiner must be 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married ò 1 ☐ Yes 2X No Specify: þ Specify: black 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Amber Davis ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Franklin Square Hospital 9000 Franklin Square Drive Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature Funeral Service Sicensee Wade, Direct Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical sture of Membranes Examiner Sequentially list conditions riany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autons performed? /es 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No I Director: / d in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral Completely filled i tif Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) Signature and itle of dertifier 09

State Registrar

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Baltimore, Maryland-21215-0036

certificate be executed

Box 68760,

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Division or Vital Records,

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Hospital

who completed cause of death (Item 23a) (Type, Print)

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State Registrar DHMH 17 Rev 1/2001

Box 68760,

Division of Vital Records, P.O.

BULTIMOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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MAY 0.8 2009

31. Date filed (Month, Day, Year)

# Baltimore, Maryland 21215-0036

Box 68760 P.O. Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 19:22 1 James V. DeJuliis OA 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reg IDNA 50/156414 HICOM.CO TENINSULA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Oct 20, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1937 Days 1 ☑ M 2 ☐ F Months Hours 71 Director 212-34-4605 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Derarment of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Examinant, ust be purified and 1 ☐ Yes 2 ☐ No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29339 Naylor Mill Road #102 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1963 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. à Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antino Perino DeJuliis Rose Dorthy Burch ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria DeJuliis/spouse 29339 Naylor Mill Road #102 Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 □Other (Specify) 21. Signature of Suneral Service Licensee Nonata 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 26 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician; The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If <u>ye</u>s, outcome of <u>pregnancy</u> 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Il Director: A 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Hearn No I St SAL 2. Registrar's Signature 100 E SAlisbury Md. 21801 31. Date filed (Month, Day, Year) State MAY 08 2009 Jark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	rtment of F tificate of		Mental Hy	/giene Reg. No. 2	109 1486
Physician /Medical	1. Decedent's Name (First, Middle, La Pauline C.	Dunsmore	2			2. Date of Do Month MAY	Day 3	2009 3. Time of Dea
Examiner	4a. Facility Name (If not institution, gi			4b. City, Town, or Betheso	r Location of Death ${f la}$	1		nty of Death gomery
Funeral Director	5. Social Security Number 333–14–7969 6.		(In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D APR 28	rth ay, Year) 1923	9. Birthplace (State or Fo Country) Illinois
n the Maryland r 28a-f show notified at irector	Usual Residence of Decedent		10c. City, Town or Loc Rockvi					10d. Inside City Li 1 ☐ Yes 2 <b>X</b>
fter death with the Mar fter death with the Mar iner must be notified funeral Director	10e. Street and Number 5750 Bou Avenu	ıe, #913		10f. Zip Code <b>208</b> 5	52		-	of What Country?
D36	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1	16a, Deced	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 A No Jent's Usual Occup	an, Mexican, Puert Specify:  pation	o Rican, etc.)	Spec	Business/Industry
21215-0 ed within 72 hou lygiene. ner than "natura nt, the Modell	Elementary/Secondary (0-12)	College (1-4or 5+	Libra	kind of work done of NOT use retired	during most or wor	KIIIY	reder	al Governme
yland 2  vuld be filed a  Mental Hygi arked other  atic event, to	17. Father's Name (First, Middle, Las	t) Lemer			18. Mother's Nan	Mos		ame)
Maryla Id 2 should Ith and Men 27 is marke traumatic	19a. Informant's Name/Relationship <b>Arthur E. Dunsmor</b>			g Address <i>(Street</i> Bou Avenu				n, State, Zip Code) 20852
Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the more.  To Be Comr	20a. Method of Disposition  1 □ Burial 2 🏝 Cremation 3 □  4 □ Donation 5 □ Other (Speci	Removal from State	20b. Place of Disposementery, crem Metro Cre	sition (Name of natory or other place	ce)	Date	20c. Location	n - City or Town, State
Balti permit. Departi Importa any inju	21. Signature of Funeral Service Lice	n. William	ns Ci	Name and Addre remation 99 Freder	Society	of Mary	land, I	inc. D 21228
figure be executed Examiner street Examiner edical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. In Urdaying Cause (Disease or injury that initiated events resulting in death) Last	a. Myocard Due to (or as a b. Due to (or as a c.	dial Infa consequence of):  consequence of):	rction				Approximate Interval Between Onset and Death hours
the death certification of the death certification of the attending iched for use a wasician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	] Ectopic pregnanc ] Other <i>(specify)</i> _	у		1	Date of delivery Month Day Year
Ords, Prequires that requires that signed brould be deta		contributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.			ontribute to the cause of death
ital Records, ian: The law requires rtificate has been sign tor, page 2 should be						1 □ Yes	opsy ormed? 2 <b>X</b> No	Were autopsy findings avail prior to completion of cause death?     □ Yes 2 □ No
> 5 6 m			t 2 K ER/Outpatien		I I Val Skilg I I		one) sidence 6 □C	Other (Specify)
Division of history of train or Attending Physical Director: After his led in by the funeral directification: To Certification: To	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  2 Homicide		y - At home, farm, stre (Specify)	M 1 🗆	yat k? Yes 2 ∐ No	28f. Location	how injury occi	urred  mber or Rural Route Number,
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the funeral Certification.	4 ☐ Homicide  29a. Certifier (Check only 2 ☐ Medical Exa	hysician: To the best of	my knowledge, death	n occurred at the ti	me, date and place	City or To	iwn, State) e cause(s) and	
o the Hosp ithin 24 hou o the Funer ompletely fil	29b. Signature and title of certifler	and manner state	ed.	29c. Licens		ared at the time		ned (Month, Day, Year)
E S E G		N Mid			60168			04 2009
3	30. Name and address of person who Asefa Mekonnen				oad, Ro	ckvill		20854
State Registrar	31. Date filed (Month; Day, Year)	32. Figistrar						

DHMH 17 Rev 1/2001

			For State	State of Ma	ıryland	•	rtment of				giene Reg. No.	2000	11.	263
			Registrar  1. Decedent's Name (First, Middle, Las	st)		007		Doam		2. Date of De		005	3. Time o	of Death
	Physici		MARY KOCHEN	DARLING						Month May	5 Day	2009 Year	6:17	A. M
-	/Medio		4a. Facility Name (If not institution, giv				4b. City, Town	, or Location	of Death			ounty of Death		
4	,		Gilchrist Hospic	e Care			Tows	son			В	altimor	e	
	Funeral		Social Security Number     6. S	DM OFF		st birthday)	If Under 1 Yea Months Day		r 24 Hrs. Min.	8. Date of Bir (Month, Da	v. Year)	Cou	place (State intry)	or Foreigr
	Director		212-10-0780 Usual Residence of Decedent	ZW 2X 1	90	Yrs.			<u> </u>	Aug. 18	3, <b>1</b> 91	18   Mar	yland	
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside C	
	Mary a-f sh	tor	Maryland N/A		Ва	altimo	re						1 <b>X</b> ]Yes	s 2∏No
	or 28	Director	10e. Street and Number				10f. Zip Code	•			10g. Citize	en of What Cou	ntry?	
	23a ust b		820 E. Lake Aver	ue				1212				U.S.A		
	tems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		. 13. \	Vas Decedent o f Yes, specify Co	f Hispanic O uban, Mexica	rigin? (Spe an, Puerto F	cify Yes or No Rican, etc.)	)- 14	<ol> <li>Race - Amer Black, White,</li> </ol>		
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show glosel Expredient rust be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 XIN If Yes, Give Year or Dates:	10	1	l∐Yes 2XXN	lo Specify	<i>/</i> :			Specify: Wh:	ite	
0-10	2 hou	ted	15. Decedent's Ed	lucation			ient's Usual Occ				16b. Kind	d of Business/Ir		
215	be filed within 72 ho ital Hygiene. id other than "natu event, In- Mydical	Completed	(Specify only highest gra	de completed) College (1-4or 5	+)	(Give life. L	kind of work dor OO NOT use reti	ired)	st of workir	ng	1.0			
21	filed wit Hygien other the	ပ္ပ	12 years				Superv					Teleph	one Co	o
ınd	be filed Ital Hygi Id other event, I	Be	17. Father's Name (First, Middle, Last,							(First, Middle				
ryla	2 should be f h and Mental   7 is marked of raumatic eve	T <sub>0</sub>	<b>.</b>	Kochen		10h Mailin	ng Address (Stre	Ann			povsk		in Code	
Ma	nd 2 sho alth and 27 is ma r trauma		19a. Informant's Name/Relationship (Mary Shelley Darl		nter)		Harcroft			onium,			21093	
ē,	P F E		20a. Method of Disposition	ing Maci	20b. Pla	ace of Dispo	sition (Name of natory or other p			ate		ation - City or T		
Baltimore, Maryland 21215-0036	permit. Pages 'Department of H Important: If Ite any Injury or of		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Į	-	ley Memor		ns. 5	-11-09	Timor	nium, M	arvlan	ıd
alti	permit. DepartmImporta any Inju		21. Signature of Funeral Service Licer		120000								<i>y</i>	
<u>m</u>	88 11 28		G. Joseph	Pellar	e	6	Name and Add tchell- 500 Yor	k Roac	l Ba	ltimore	, Mai	ýland	21212	)
Г			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. e.	Do not ent	er the mode of o	dying, such a	s cardiac o	r respiratory a	arrest,		Approxima Interval Be Onset and	etween
	Physician		Immediate Cause (Final disease or condition	a. Comp	LICA	TON	SOF	HIP	FRA	CTURE				KS
agt.	/Medical Examiner		resulting in death)	Due to (or as				•	1		1	.(		
ь		e.	Sequentially list conditions,	b. Due to (or as	a conseque	ence of):		000	000	17	Sat.	7		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	,		,	A	PRIO	11	1.0.	' N	, b.		
o,	an and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):		T. Verl	JAKE !	1.6	10,			
8760,	requires that the death certificate be executed been signed by the aftending physician and hould be detached for use as the burial-transit	dical	•	d				My will	1	11110				
9	ertific ling pl	Med	IF FEMALE:				1	Th	1.6					
Вох	eath certific aftending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗀 Fetal	death 3 ☐	Ectopic pregna				23	3d. Date of deli Month	very Day	Year
Ö	that the deneed by the a	ysic	in the past 12 months? 1 □Yes 2 No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	time of de	ain 5L	Other (specify)	/						
σ.	that i		Part II. Other significant conditions	ontributing to death b	ut not resul	ting in the u	nderlying cause	given in Part	: I.	23e. Did	tobacco us	e contribute to	the cause of	f death?
rds	w requires that s been signed t s should be deta	d by	DEMENTIA							1 🗆	Yes 2	<b>C</b> No 3□ Pro	obably 4	Unknow
006		Completed								24a. Was		24b. Were au	topsy finding completion of	s available
Ä	The ate h	mo								perfe	ormed?	death?	_	oduse of
Division of Vital Records,	Physician: The faw this certificate has tral director, page 2 s	Be (	25. Was case referred to medical examiner?						ce of Death	(Check only	_			
of \	> .50 70	2	1 Yes 2 No				IL 3 LI DOA			me 5□Res		Other (Spec	city) Hast	PICE
n	ding Ph h. After th funeral	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	v, Year)	28b. Time of Injury	V	njuryat Vork? □Yes 2 <b>)</b>		28d. Describe FALL		occurred		
isi	l or Attending after death. Director: After in by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not b	/// KIC / C/		ne, farm, str	4,4	<u> </u>	-			Number or Ru	ıral Route Nı	umber,
οŚ	after after Dire	Certification:	4 Homicide determined	28e. Place of Injubulding, etc.	Homa				,	City or To	wn, State)	K , BALT	MADE A	WA 2121
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a. Certifier 12 Certifying PI	nysician: To the best	of my know	vledge, deat	h occurred at the	e time, date	and place,	and due to the	e cause(s)	and manner as	stated.	a(e)
	he Ho in 24 he Fu	Medical	(Check only 2 Medical Example)	and manner sta		on and/or in				eu at the time				
	To the within 2.	Σ	29b. Signature and title of certifier				29c. Lice	ense number	2			e signed (Monti		
								4434	15		MAY	10,11	001	
	101		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)	· S1117	ZON	RA	15101	15,20	1 0	nel
	Sta	te.	OHNIEUE UOSTFM 31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	ure	barks 81	roull	c wi	On	41110	ore, pri	0 410	LUT
	Registr		MAY 08	2009	un	1. 1	back	*						
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 5:00<sup>P м</sup> Stewart Berryman Eckers 07, May 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oakcrest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09/10/1920 Birthplace (State or Foreign Country) **Funeral** Days Hours 1**℃** M 2 🗆 F 219-01-1842 88 Director Baltimore, MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Parkville Director MD Baltimore 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 🏿 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Packaging Company Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Owner/Self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Eckers Ardelia Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki L. Heavel/ Friend 1410 Valbrook Ct. South, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/12/09 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licenses Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee

Evans Funeral 1 Chapel & Crema 8800 Harford Rd. Parkville,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the set failure. List only one cause on such line. 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia Laus /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lusease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Varing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide PRACTITIONER Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

Examiner certificate be executed P.0. Vital o To the Hospital or Attending F within 24 hours after death.
To the Funeral Director; After t

ed by the attending physician detached for use as the buria

has

certificate

completely filled in by the funeral director,

r than "natural", or items 23a or 28a-f show

filed within 72 hours after death

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I

Baltimore, Maryland 21215-0036

Records,

State DHMH 17 Rev 1/2001

20

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Justine Preis

WALTHER

and manner stated.

News CRAP.

8832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLVD BALTO. MD

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 14865

		- For State egistrar				Certin	ficate of	Death			Re	g. No.	. 0 0	7 1400
Physician/ Medical Examine	1	, Decedent's Name	(First, Middle Kennet	h El	lis						Date of Deat Month May 6, 200	Day Yes	ar	3. Time of Death 1620 hrs
( )	4	a. Facility Name (i 867 Holly Di		n, give stree	et and number)		4	o. City, Town, Annapolis		of Death		4c. County Anne A	rundel	
Funeral Director		5. Social Security N 235–90–50	42	6. Sex		n yrs, last 53	birthday) Yrs.	If Under 1 Your Months Da	_	er 24Hrs. Min.	8. Date of Birl	1955	9. Birth Foreign Cou	7.77.7
and show any nice.	ľ	Jsual Residence of 10a. State MD	Decedent 10b. County Anne	Arund			own or Location							10d. Inside City Limits  1 Yes 2 XNo
the Maryland 23a or 28a-f show offited at once.		10e. Street and Nur 867 Holl		e Sou	th			10f. Zip Code 21409			1	Og. Citizen of W United		
s after death wir rral", or items?	≩ -	11. Marital Status 1 Never Marrie 3 Widowed 15. Decedent's Ed	4 Div	orced If Yes	s, Give Year ates: hest grade compl	No eted) 1	1 1 6a. Deceden	S Decedent of less, specify Cub  Yes 2  Yes 2  'S Usual Occup  set of working by	oan, Mexican  No specify:  pation (Give	kind of wo	ork done		te, etc. Whi	
5-0036 ed within 72 hour lygiene. other than "nation he Medical Example Commission of the Commission of the Medical Example of the Medica	Iblete	Elementary/Seco	ondary (0-12)	2	College (1-4 or 5+	)		Employ	yed Co	ntrad	ctor	Contra		g
215-00 be filed wintal Hygie riked other ent, the M		17. Father's Name William							Sigr	id I	Bailey	Maiden Surnam		
MD 21 12 should th and Me 127 is man umatic ev	2	19a. Informant's Na Renee El			Print )		8100	Pineber	ry Co	urt,	803, F	nber, City or To Pasadena	, MD	21122
nore, land sign of the stand of		20a. Method of Dis 1 X Burial 2	Cremation		emoval from State	cre	ematory or oth	ition (Name of her place) Mem . Go	-	05/09	Date 9/2009	20c. Location	•	
Baltin permit. Pe Departmen Importan injury or	1	4 Donation 5 21. Sig Fu	ın al Service	Licensee		VE (	23	1 West	Cumbe	rland	d Road,	Bluefi	eld,	WV 24701
Physician /Medical ;aminer		23a, Part I. Enter the failure. List on Immediate Cause or condition resulti	nly one cause (Final disease	on each lin		eroti						rest, shock, or h	eart	Approximate Interval Between Onset and Death
	ler	Sequentially list co	onditions, mmediate	b	o (or as a conseq						-			
ed	Examin	cause. Enter Unde (Disease or injury) events resulting in	that initiated	c Due t	o (or as a conseq	uence of):	-							
760, reate be executed physician and the burial - transit	Medical	XUNPENDED	)		<sub>IENDED</sub> 23a			G892 6	/4/09	ТТ		Look Date	- f - 1 - 1	
.O. Box 68760, that the death certificate by the attending physic detached for use as the but	sician	IF FEMALE: 23b. Was decedent past 12 month	s?	ne 1	C. If yes, outcome Live birth Pregnant at ti		2 Fe	tal death her (Specify)	3 Ectop	oic pregna	ncy	23d. Date Month		y Day Year
P.O. E es that the digned by the detached	2	Part II. Other sign	ificant condi	tions cont	tributing to death	but not res	sulting in the	ınderlying cau	se given in F	Part I.				the cause of death?
Cords, law requir has been s	Completed										24a. Was auto perf	psy ormed?		utopsy findings available completion of cause of es 2 No
Vital Recysician: The system: The his certificate director, page	å R	25. Was case refe examiner?		Hospi	tal: 1 Inpatien	+ 2	ER/Outpatien		lace of Deat		g Home 5	Residence 6	Othe	r: Scene
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Division pital or Attendia ours after death. teral Director: A	Certification:	2 Accident 3 Suicide 4 Homicide	6 Cou	estigation ald not be ermined	28e. Place of Inju	ıry - At ho	me, farm, stre	et, factory, offi	ce building,	etc.	28f. Location or Town,		mber or Ru	ural Route Number, City
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To with To Corr	Me	29b. Signature and	d title of certif				-		cense numbe .C.M.E.	er		29d. Date si May 7, 2		onth, Day,Year)
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Old Star Registra		31. Date filed (Mor	nth, Day, Year	2000	32 Kegistrar	s Signatui		Ke						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decede t's Name (First, Middle, Last) a009 /lonth **Physician** towlkes, Jr. May Kenne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, Examiner Baltimore trondal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Pay, 1934 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**Ø**M 2□ F 217-30-4540 Months Days Min. Hours Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is included. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Mares 2 □ No Baltimore **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA Hvondale 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Black Ś 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be owl Kes 0 ames orown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Tyr Balto, mp 21a 20c. Location - City or Town, State MD 21229 ra towikes aughter 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 🗡 Burial 2 🗆 Cremation 3 🗆 Removal from State Wings Mills. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Fune al Service Licensee s of Folity 6 one Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
Thenulas to local shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) marcian My Cardial Physician /Medical Due to (or as a consequence of) Orona Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Mallelier Dialole Due to (or as a consequence of) physician The law requires that the death certificate be Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown á signed by be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Blessly si clomia 1 Yes 2 🗌 No 3 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 12 No 1 □Yes the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000415  $\mathcal{M} \cdot \mathcal{D}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Ballimon MA HEMANI 10. North ALNOOR M.D 31. Date filed (Month, Day, Year) 32, Registrar's Signature State part Registrar DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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aryla should the and Men s market umatic	19a. Informant's Name/Relationship	o (Type. Print)	19b. Mailing	Address (Street			; City or Town, State,	Zip Code)			
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to con	29b. Signature and title of certifier  M. Jokhau	la Maria	27	29c. Licens	6076	8	9d. Date signed (Mon 5/6/0 e/Ai'/	th, Day, Year)			
6	30. Name and address of person when M. Tokhad electric	no completed cause of death (It	tem 23a) (Type, Pri	nt) Csafe	ak Di	., Bo	el Air,	MB101			

DHMH 17 Rev 1/2001

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				For State Registrar		Otato of Mic	ii y iai io	Cei	tificate of	Death	Wiorital 1 ly	Reg. N	0.	
				1. Decedent's Name	(First, Middle, Las	st)					2. Date of De Month		ay Year	3. Time of Death
		Physicia /Medic		Dean R	. Green						April	30	, 2009	8:25 PM M
4	and the same of th	Examin		4a. Facility Name (If I	not institution, giv	e street and number)			4b. City, Town, o	r Location of Dea	th	4	c. County of Deat	
	· K				Maris H	ospice			Lutherv				Baltimo	
		Funeral Director		5. Social Security Nul 218-68-	-6090 <sup>1</sup>	ex 7. Age M 2□ F	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ay, Yea 19	9. Bird 057 Per	thplace (State or Foreign ountry) nnsylvania
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				30. Name and addre	ss of person who	completed cause of d	eath (Item	23a) (Type,	Print)				, , ,	
				JACKIE JO		NP 2300 DI	ULANE	Y VAL	LEY RD.	TIMONIUM	1, MD 210	093		
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Physic		Marion	Ĺ.			Gardne	er	Month May	6 2009 ear	7:45 P M
/Med Exam		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Death		4c. County of Dea	ath
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Funera		5. Social Security Number 6. S	Sex 7. Age I□M 2□F	(In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year) C	rthplace (State or Foreign country)
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ryland thow	_	10a. State 10b. County		10c. City, T		cation				10d. Inside City Limits
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death ns 23 must	Funeral	8122 Dunda1k	12. Was Decedent E	ver in U.S.	13. \		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		
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e, n 1 and Health em 27 ther t		Michael Pugh 20a, Method of Disposition	(Son)	20b. Plac		Apt. C. sition (Name of matory or other place			Bowleys Qua 20c. Location - City of	arters, Md.
rior ages ent of tt. If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci					1	8,2009		
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		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. e.						Approximate Interval Between
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law ras be	Completed							24a. Was	psy prior to	autopsy findings available completion of cause of
The The cate h	Con							perfo 1□ Yes	ormed? death?	
VILAI sician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Hospital:			ot 3DDOA Oth	26. Place of Dea	4		
Physer this eral di	1: To	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpatie	y 28	8b. Time of	I OLI DON	4 Linuising F		dence 6 □Other (Sp how injury occurred	ecify)
SIOII ttending leath. tor: Afte the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day n	r rear)	Injury		Yes 2 No			
r Atte er deg recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home c. (Specify)	e, farm, str	eet, factory, office		28f. Location (- City or To	Street and Number or I wn, State)	Rural Route Number,
itai o Irs aft Iral Di		A-2-								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		hysician: To the best of miner: On the basis of and manner sta	examination						
o the	Mec	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (Mod	nth, Day, Year)
PSFO		> William 6	On Au	cie.	Nen	710	5801		O7 MAY	12009
1 ./	,	30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type,	Print)		/ /		
I V		9103 Frank	lin Squa	re 0	<u>ታ ·                                    </u>	Ste 22	ov Ba	litomor	e, MD o	21251
S Regis	State strar	30. Name and address of person who 9/03 Frank 31. Date filed (Month, Day, Year)  MAY 0 7 2009	Ja. Hegistra	si s Signatur	ha v	20				
DHMH 17 Rev 1		PIM 1 0 1 2003	parame	1. 19	- wo					

09-03289	
Decele Oil d	

9-03289		Please Type or Print in Black Indelible Ir		
resly Gilland		State of Maryland / Department of		2009 1487
		1- For State Registrar 1- Decedent's Name (First, Middle,Last) Certificate of	Death Re	g. No. 3. Time of Death
Physicia Medical Exami		Presly Gilland	Month April 24, 20 4b. City, Town, or Location of Death	Day Year 0950 hrs
		4a. Facility Name (if not institution, give street and number)  604 South Newkirk Street	Baltimore	46. County of Death
Funeral Director		5. Social Security Number $\frac{1}{2}$ 6. Sex 7. Age (In yrs. last birthday) 1. XM 2. F 52 Yrs	Months Days Hours Min.	h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) unk 5, 1956
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati	ion	10d. Inside City Limits
<b>*</b> .	٦	MD Baltin		1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 604 S. Newkirk Street	10f. Zip Code 21224	g. Citizen of What Country? USA
death with the retitems 23a	Funeral		is Decedent of Hispanic Origin? (Specify Yes or No- es, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
after	by F	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:	Specify: white
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi injury or other traumatic event, the Medical Examinar must be notified at once	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	nt's Usual Occupation (Give kind of work done ${ m unk}$ ost of working life. DO NOT use retired)	16b. Kind of Business/Industry unk
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		unk unk  17. Father's Name (First, Middle, Last)	unk 18.Mother's Name (First, Middle, M	I Maiden Surname) unk
2121 Ild be f Mental narked event,	o Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing	g Address (Street and Number or Rural Route Num	iber. City or Town. State. Zip Code)
MD 2 nd 2 shou alth and 1 m 27 is a	-		Penn Street Baltimore,	
re, range tranger	Ì		sition (Name of cemetery, Date	20c. Location - City or Town, State
altimore, rmit. Pages I a spartment of He program: If ite jury or other tr		4 Donation 5 X Other Specify: in starte		
Balti permit. Departm Imports injury o			Name and Address of Facility ate Anatomy Board 655 W	
Physician		23a. Patt I. Enter the disease, or complications that caused the death. Do not enter the	1timore, MD 21201 he mode of dying, such as cardiac or respiratory arro	est, shock, or heart Approximate Interval
· /Medical		failuce. List only one cause on each line.  Immediate Cause (Final disease a. Complications Of Chronic Alcohol a.)		Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):		
	<u>ا</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):		
_	Examiner	cause. Enter Unicerlying Cause (Disease or injury that initiated		
xecuted 1 and - transit		events resulting in death) Last Due to (or as a consequence of): d.		
8 8 8	ical	UNPENDED AMENDED		
Box 68760, c death certificate be execute the attending physician and ed for use as the burial - tran		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery
certification of the certifica	cian	past 12 months?	etal death 3 Ectopic pregnancy ther (Specify)	Month Day Year
Box e death the atte	hysi	1 Yes 2 No 9 Unknown g Unknown		
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be death.  Retor: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the buri	by P	Part II. Other significant conditions contributing to death but not resulting in the u		bbacco use contribute to the cause of death?  S 2 No 3 Probably 4 V Unknown
ords, I	ted		24a. Was	
COF	Completed			rmed? death?
Vital Rec ysician: The l his certificate l		25. Was case referred to medical	26.Place of Death (Check only one)	2 No 1 Yes 2 No
Vita hysicia this cer	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	t 3 DOA Other A Nursing Home 5	Residence 6 🗸 Other: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Ë	27. Manner of Death 1 ✓ Natural 5 Deading (Month, Day, Year) 28b. Time of (Month, Day, Year)		how injury occurred
ivisior or Attend after death Director:	catic	Natural 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, stre	1 Yes 2 No	Street and Number or Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, S	
Divis: To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occuone)  Medical Examiner: On the basis of examination and/or investiga	irred at the time, date and place, and due to the caustition, in my opinion, death occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To wit	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		flessell willow min	O.C.M.E.	April 24, 2009
	1	30. Name and address of person who completed cause of death (fiem 23a)	11 Ponn Stroot Politimers MD 04004	
		Pamela E. Southall, MD Assistant Medical Examiner 11	11 Penn Street, Baltimore, MD 21201	

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of Ma	aryland / Depa <i>Cer</i>	rtment of F tificate of			giene Reg. No. 🤈 🕦 🖺	10 11.071
			1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath CU	3. Time of Death
	Physicia /Medica		Stanley Edward Hooker				MAY	03 20	09 12:10 AM
	Examine	er	4a. Facility Name (If not institution, give street and number)  S1. AGNES HOSPITAL		**	r Location of Death		4c. County of I	Death I/A
	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th 9	Birthplace (State or Foreign
	Director		214-62-6030 1X M 2 F	55 Yrs.	Months Days	Hours Min.	Feb. 2	6, 1954	Maryland
	and and	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
	Mary a-f sh	혅	MD Baltimore		Baltim	ore			1 □Yes 2 No
	or 28	Dire	10e. Street and Number		10f. Zip Code	21207		10g. Citizen of Wha	
	eath w	Funeral Director	7000 Alter Street  11 Marital Status 12. Was Decedent 8	Ever in U.S. 13 V		21207	pecify Yes or No	United S	American Indian,
Baltimore, Maryland 21215-0036	1.0 a	ρ	11. Marital Status  1 □ Never Married 2 □ Married  3 ₩ Widowed 4 □ Divorced  1 □ Yes, Give X Year or Dates:	VIO.	Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, \ Specify:	White, etc. White
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give )	ent's Usual Occup kind of work done	pation during most of work d)	king	16b. Kind of Busin	· ·
121	within ene. than'	dmo	Elementary/Secondary (0-12) College (1-4or 5	p+)	nteneace			Turf Va	
Jd 2	e filed al Hygi other	Be C	17. Father's Name (First, Middle, Last)		ricericace		ne (First, Middle	, Maiden Surname)	Oldo
ylar	Ments Ments arked atic ev	2	Joseph William Hooker					a Arndt	
Mar	d 2 sho		19a. Informant's Name/Relationship (Type. Print)  Brian Anderson/Brother-ir					er, City or Town, Sta .timore, M	
ē,	s 1 an if Heal item 2 other		20a_Method of Disposition	20b. Place of Dispos			Date Date	20c. Location - Cit	
<u> </u>	Page nent c ant: If ury or		Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Loudon Par	rk Cemet	ery 5-7-		Baltimo	
Salt	permit. Departimports any Inj	1	21. Supply Finaral Service biconse					uneral Ho	
	70 = 40 O	-	23a. Fart I, Enter the disease, or complications that caused	-				rbutus, M	Approximate interval Between
	Physician	4	shock, or heart failure. List only one cause on each lir Immediate Cause (Final	ne.		ENAL CE			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a Due to (or as	a consequence of):					
	Examiner	_	Sequentially list conditions, if any leading to immediate b. Due to (or as	a consequence of):					
\ <u>\</u>	uted I Insit	Examiner	Cause (Disease or injury	a consequence or).					
0,			that initiated events resulting in death) Last C Due to (or as	a consequence of):					
09289	ate be	dical	d						
	certific Iding p	/Mec	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d. Date	of delivery
Box	death certif e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnand Other (specify)	су		Month	
P.O.	at the	hys	9 ☐ Unknown				00 5:1		and the server of death?
A A L	es t igne	ğ	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause gi	ven in Part I.			ute to the cause of death?
SiA.	law ru has be	Completed					24a. Was	psv pri	ere autopsy findings available or to completion of cause of ath?
-	n: The ficate r, pag	Co					1 □ Yes	2 No 1	Yes 2 □ No
Vital	/siciar s certii directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatie	ent 2 ☐ ER/Outpatien	nt 3 🗆 DOA Oti	26. Place of Dea her: 4 ☐ Nursing H		one) idence 6 ☐Other	(Specify)
HOOKER	Attending Physician: r death. ector: After this certific by the funeral director, i	n: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju (Month, Da	ury 28b. Time of				how injury occurred	
五点	tendir leath. tor: A the fu	catic	2 Accident investigation		M 1 [	]Yes 2□No	29f Location	(Ot	an Dunal Pauta Number
H <sub>0</sub> (	l or At after d Direct	Certification: To	4 Homicide determined 28e. Place of inj	jury - At home, farm, stre c. (Specify)	eet, ractory, onice		City or To	wn, State)	or Rural Route Number,
h		Medical C	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best 2 ☐ Medical Examiner: On the basis of and manner st	of examination and/or in	n occurred at the t vestigation, in my	time, date and place opinion, death occu	e, and due to the arred at the time	e cause(s) and man	ner as stated.  Indicate to the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of certifier			se number			(Month, Day, Year)
		(1)	Dr. Hokur		72	0166		MAY	02,2009
			30. Name and address of person who completed cause of completed cause of the SAMUEL NOLLURI	death (Item 23a) (Type,	Print)	VE BAL	TIMORE	MD 21	229
	Stat	te		rar - Signature	A-	VE, BAL		y (M1)	
	Registra		31. Date filed (Month, Day, Year) 32. Regett	wa d. s	barker				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 5, Alice Hancock May 2009 5:05 A M Martha /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Eastpoint Future Care Northpoint If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year)
Jan. 30, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 ☑ F Ohio Jan. 85 Director 297-12-6123 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Exprised to 15 to 1 □Yes 2 No Baltimore Edgemere Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code United States 21219 Funeral 3105 Greenhill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 25 No Specify: þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Maranovich ဥ William Bielawski 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3105 Greenhill Road Edgemere, Maryland Mr. Ernest Ashton Hancock 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem, 5/8/2009 Rossville, Maryland Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Ave. Dundalk, Maryland 7922 Wise 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEROSCUEROTIC ARDIN VASCULAR **Physician** DISEASE disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) □Yes 2 →No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>S</u> 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **N**0 2 No 1 □ Yes 25. Was case referred to medical examiner?

/Medical

Baltimore, Maryland 21215-0036

Box 68760, P.0.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, To the Funeral Director: completely filled in by the within 24 hours after To the Funeral Direc

Be

Certification: To

Medical

1 Tes 2 No

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifie

4 Homicide

Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

PANKA

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

KHETERVA

28a. Date of Injury (Month, Day, Year)

and manner stated

who completed cause of death (Item 23a) (Type, Print)

9106

Registrar's Signatu

State Registrar 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

W. D.

28b. Time of injury

28c. Injury at

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D6066 500

1 Yes

2 🗌 No

ADELHIA PS # 208,

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#2perPHYS, G891, 5/8/09, WS
State of Maryland / Department of Health and Mental Hygiene G891-5/115/09 of Beath amend #7 Per FH Reg. No. 2 2. Date of Death Month 05/04ay 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 9:45 PM /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ltimor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🔽 F Days Months 43 Director MD miltimare Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Inspired. 17. Father's Name\_(First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Type. Print) 19a, Informant's Name/Relationship Father-In-lau. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City of Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 5 ☐Other (Specify) 4 □ Donation 21. Signature of Juneral Service Licensee 22 Name and Address of laci Newport 111081 PORST HILL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death (he Civer Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, begoing to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner THE BOTOM OF SHOWING ON THE requires that the death certificate be exec Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has a lirector, page 2 st autopsy 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No sce 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto and ZIZOX Gome 6 egistrar's Signature 32 State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 14874

William Frederick	1	sher - For State legistrar	State o	f Marylan	d / Departi <i>Certif</i>	ment of <i>licate of</i>		d Mental		2 U 1g. No.	109 148	İ
Physician Medical Examine	1/	1. Decedent's Name (I	First, Middle,Last) m Freder	ick Hil	sher				2. Date of Deat Month April 24, 20	Day Year	3. Time of Death 2115 hrs	_
<b>(</b> )		4a. Facility Name (if n	ot institution, give				lb. City, Town, or Rosedale	Location of D		4c. County of I		
Funeral Director		5. Social Security Nun	nber 6. Sex	7. M 2 F	Age (In yrs. last	birthday) Yrs	If Under 1 Year Months Day		Min. 8. Date of Birth	F	9. Birthplace (State or Foreign Country) Mary1and	1
any		Usual Residence of D			10c. City, To	wn or Locati	on		indi 25	1722	10d. Inside City Limit	
<b>*</b>	اڄ		Baltimor	e		altimo					1 Yes 2 X	
the Maryland as or 28a-f show officed at once.		10e. Street and Numb			- · ·		10f. Zip Code 21	234	10	ng. Citizen of What USA	t Country?	
or death with	lie	11. Marital Status  1 Never Married	2 Married	Armed Ford	ent Ever in U.S. es? 2 X No	If Y	es, specify Cubar	n, Mexican, Pu	( Specify Yes or No- erto Rican, etc.)	White,		
urs after tural",	⋧┞	3 Widowed  15. Decedent's Educ	4 X Divorced training (Specify only		completed) 16	Sa. Deceden	Yes 2 X No t's Usual Occupa	tion (Give kind		Specify: 16b. Kind of Busin		
5-0036 led within 72 hour Hygiene. other than "natu the Medical Exan	Complete	Elementary/Second	lary (0-12)	College (1-4		during m	ost of working life ware eng	. DO NOT use		Black	& Decker	
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2121. ould be fill ould be fill ould be fill ould be fill out of Mental I s marked tic event,		19a. Informant's Name		oe, Print )		19b. Mailing	Address (Stree		th Happel or Rural Route Num		State, Zip Code)	_
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3 .nd	2	29b. Signature and title	e of certifier				29c. Licens	se number M.E.		29d. Date signed April 25, 200	d (Month, Day, Year)	
OGME OGME	3	30. Name and address Mary G. Ripp	1/	•	of death (Item 23	,	Penn Stree		 e, MD 21201	7 15.11 20, 200		_
Stat	~	31. Date filed (Month)	Day, Year)	32. Regi	strar's Signature							_
Registra			AY 0 8 20	091 <i>Se</i>	me de		Mad					_
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 1050 PM 2009 Elaine Vivian Hartlove 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Season's Hospice Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 M XXF 74 219-32-5268 Dec. 3, 1934 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Glyndon Drive 21136 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 Yes XXNo 1 Never Married XX Married 1 ☐ Yes X2 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Elmer Wolf Emma Rose Hoffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Glyndon Drive Reisterstown, MD 21136 John Hartlove / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans 20a. Method of Disposition 20c. Location - City or Town, State X I Burial 2 ☐ Cremation 3 ☐ Removal from State 5/8/09 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD Cemetery 21. Signature of Juveral Pervice License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE CARDIOMYOPATHY Due to (or as a consequence of) CORONARY MITERY DISEASE Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

physician

signed by the attending the detached for use as

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within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

within 2 To the F

Physician/Medical

3

Completed

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Certification:

Medical

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Attending Physician:

Hospital or 24 hours

the

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

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**Funeral** 

Director

the Maryland 3a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

d other than "natural", or Items 23a event, I'm Medical Examiner vust t

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, I a. M. any Injury or other traumatic event, II a. M. any Once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar

Diabotos Mollitus

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an

Renal tailure anoxic encephalopathy 25. Was case referred to medical examiner?

autopsy performed 1 ☐Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 No

1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

1445931

29d. Date signed (Month, Day, Year)

Debble Burton 31. Date filed (Month, Day, Year)

2335 Smith Ave suite 203 Baltimore MOZIZO9 32. Registrar's Signature

State Registrar

			1 - For State Registrar Amend I	State of Ma tem 25 per	aryland <b>me,g8</b>	/ Depa <b>91 ,05</b>	artment o	of H	ealth a Death	and M	1ental Hy	/gien Reg. N	00	<b>n</b> 9	149	378
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	Physici /Medio		ROBERT K		WAY	<b>,</b>					APRIL			2009	08:	20 <sup>M</sup>
A. Sec.	Examin	er	4a. Facility Name (If not institution,		ME	DECAL	4b. City, Tov					4	c. County	of Death		
and the			JOHNS HOPKINS  5. Social Security Number  6		e (In yrs. las	ENTER	If Under 1		If Under	-	8. Date of Bi	rth		9 Birthn	lace (State o	or Foreign
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	arylar show	<u>_</u>	10a. State 10b. County		,,	Town or Lo								11	0d. Inside Cit	
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ဖ	or iter	F	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 [X] N			f Yes, specify	Cubar	n, Mexican	, Puerto	Rican, etc.)			ck, White, e		
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a	sh and sh	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (S	Street a			al Route Numi			State, Zip	Code)	
Ž	and 2		Tammy Haddaway/s	sister		2121	Linco	1n	Aven	ue B	altimo	ce,	MD	21219		
ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Eraminer must be retified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□ Romoval fra <b>r</b> State	20b. Pla	ce of Dispo	sition (Name natory or othe	of er place	)		Date	20c.	Location -	City or To	wn, State	
Ē	Pag tment tant: jury o		4 □ Donation 5 🖾 Other (\$pe	cify) in state				_	!							
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health of Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Secuce Li	Wade, Dire	ector		Name and A ate An altimor		-		655 W	. Ва	1tim	ore S	treet	
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mel.	Physician		Immediate Cause (Final disease or condition	BEA:		DEA	TH							<u> </u>	Onset and E	Death
-e07	/Medical Examiner		resulting in death)	Due to (or as a	a conseque	nce of):					··· -					
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Ć.	exec an and ial-tra	Еха	that initiated events resulting in death) Last	C. Due to (or as a			11017		• •	CATION	APPROVED					
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89	ertifica ing ph e as th	Med	IF FEMALE:													
Box	eath certifii attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 🗌 Fetal d	eath 3[	Ectopic preg							te of delive	,	Year
	he de the a	ysic	1 □Yes 2 □ No 9 □ Unknown	4 ∐ Pregnant at 9 □ Unknown	t time of dea	ath 5	Other (speci	ify)					1410	,,,,,,	,	
J,	uires that the de signed by the a d be detached f		Part II. Other significant condition	s contributing to death bu	ut not resulti	ng in the u	nderlying caus	se give	n in Part I.		23e. Did	tobacco	use con	tribute to th	ne cause of d	leath?
Records,	uires n sign Id be	d by									1 🗆	Yes	2 🗌 No	3 ☐ Prob	ably 4	Jnknown
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r	The law ate has bage 2 s	ф									auto			prior to coi death?	mpletion of c	ause of
Vitai	sician: The la certificate ha rector, page 2	Be C	25. Was case referred to medical			-			26. Place	of Deatl	1 ☐ Yes		10	1 □Yes	2 LI No	
01 <	S 0 75		examiner? 1 <b>X</b> Yes 2	Hospital: 1 Inpatie	nt 2 EF	R/Outpatier	nt 3 🗆 DOA	Other			me 5□Res		6 □Otl	ner (Specif	v)	
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DIVISION	or Al after o Direct in by	Certification: To	4 Homicide determine		iry - At hom :. (Specify)	e, farm, str	eet, factory, of	ffice			28f. Location City or To	(Street a wn, Sta	and Numl ite)	oer or Rura	l Route Num	ber,
_	spital hours neral y filled		29a. Certifier 1 Certifying	Physician: To the best of	of my knowl	edge, deat	n occurred at	the tim	e, date an	nd place,	and due to the	e cause	(s) and m	anner as s	tated.	
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			30. Name and address of person wh	y. /	eath (Item 1	(3a) (Typo		= 5	- 00	0		rt Y k	はし	68	,200	) [
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State Registrar DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

2009 14877

Ale   Facility Name (if not institution, give street and number)   Ale   County of Death	10d. Inside City Limits 1
Johns Hopkins Hospital  Baltimore  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Whoths Days Hours Min.  10a. State  10b. County  10c. City, Town or Location  10c. City, Town or Location  10d. Street and Number  10d. Street and Number  10d. Street and Number  10d. Street and Number  10d. Street and Number  10d. Street and Number  10d. Street and Number  10d. Street and Number  11d. Marital Status  11d. Marital Status  11d. Marital Status  11d. Marital Status  11d. Marital Status  11d. Was Decedent Ever in U.S. Armed Forces?  11d. Never Married  11d. Was Decedent Status  11d. Marital Status  11d. Marital Status  11d. Marital Status  11d. Marital Status  11d. Marital Status  11d. Marital Status  11d. Was Decedent Ever in U.S. Armed Forces?  11d. Never Married  11d. Race - Americal Marri	10d. Inside City Limits 1
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The state of the s	
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15. Decedent's Education (Specify only highest grade completed)    16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)    16b. Kind of Business/In during most of working life. DO NOT use retired)	acic
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if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
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Standard St	topsy findings available ompletion of cause of
The state of the s	s 2 No
25. Was case referred to medical examiner?  1 Ves 2 No  1 Inpatient 2 ER/Outpatient 3 DOA  Other:  1 Ves 2 No  28 Date of lighter 2 28	:
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29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (More May 3, 2009)	nth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	
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			For State	State of Ma	arylan		artment of F rtificate of I			giene Reg. No 20	09	14878
			Registrar  1. Decedent's Name (First, Middle, L	.ast)					2. Date of Dea	ath	Vasa	3. Time of Death
	Physicia /Medic		William Maynard	d Jarboe					May 4,	2009	Year	2:00 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, g					Location of Death			ty of Death	
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	'n		Usual Residence of Decedent							<i>y</i> 1.21.7.		
	arylar show	<u>_</u>	10a. State 10b. County			, Town or Lo						0d. Inside City Limits 1 □Yes 2 🛣No
	the Mi	Director	MD Montgor  10e. Street and Number	nery	Gern	antow	10f, Zip Code			10g. Citizen of	What Cour	itry?
	aa or	Ö	13500 Deakins La	ane			20874			USA		
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715	in 72 9. In "na Medic	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	(±)	(Give life.	kind of work done DO NOT use retired	during most of work d)	ing			
21	d with	Com	12	- College (1 40) 0	,,,	Busin	ess Owner	_		Printi		ipany
ng	be file	Be	17. Father's Name (First, Middle, La Austin Jarboe	st)				18. Mother's Nam		Maiden Surna	ime)	
Z	hould of Mer marke matic	ပ္	19a. Informant's Name/Relationship	(Time Print)		10h Maili	ng Address (Street		_	er City or Tow	n State Zir	Code)
Z S	nd 2 s lith an 27 fs i		Loretta Jarboe H		r	i	2 Mosel T					
re,	is 1 ar of Hea item othe		20a. Method of Disposition				osition (Name of matory or other place		Date	20c. Location		wn, State
<u>im</u>	Page ment c ant: If ury or		1 ☐ Burial 2 ② Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				el Cremat		06/09	Odentor	n, MD	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Immortant: If time Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Engineering to other traumatic event, the Medical Engineering to other traumatic event, the Medical Engineering to other traumatic event, the Medical Engineering to other traumatic event, the Medical Engineering to other traumatic event, the Medical Engineering to other traumatic event, the Medical Engineering to other traumatic event, the Medical Engineering to other traumatic event, the Medical Engineering to other traumatic events and the Medical Engineering to other traumatic events are the Medical Engineering to other traumatic events and the Medical Engineering to other traumatic events are the Medical Engineering to other traumatic events.		21. Signature of Funeral Service Lie	ensee/ //	,		Sing and Addre					
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	Novelelen (		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lir Prostate			ior and mode or dyn	ig, sasii as saraias		,	9.1	Interval Between Onset and Death O years
j	Physician / /Medical		disease or condition resulting in death)	Due to (or as								o years
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	sit s	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):						
10	execut n and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):						
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical I		d								
89	artifica ing ph as th	Medi	IF FEMALE:									
Вох	ath ce attend for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Feta	Ideath 3	☐ Ectopic pregnand	у		1	ate of deliv Month	ery Day Year
o	the de y the	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unknown	it tillle of d	leaui 51	Other (specify) _					
ď.	ires that the de signed by the be detached t	by Pł	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did t	obacco use co	ntribute to t	he cause of death?
ğ	w require been signated by should by								1 🗆 '	Yes 2. ZXNo	3☐ Pro	bably 4 Unknown
ecc	law ra nas be s 2 sho	Completed							24a. Was autoj	osy	prior to co	opsy findings available ompletion of cause of
E F	ician: The certificate rector, page								1 □Yes		death? 1 ☐ Yes	2 □No
Vit	siciar certifi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🄀 No	Hospital:	ent O	ED/Outnotic	nt 3 □ DOA Oth	26. Place of Dea	th <i>(Check only c</i> ome 5 <b>X</b> Resi		thor (Canad	
of	ding Physician: The h. h. After this certificate h. funeral director, page	n:To	27. Manner of Death	28a. Date of Inju	iry	28b. Time of Injury			28d. Describe			197
jo	ending F sath. or: After he funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	iy, reary	Highly		Yes 2□No				
Division of Vital Records,	or Attenc after death Director: I in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At ho c. (Specif	ome, farm, st	reet, factory, office		28f. Location ( City or To		nber or Run	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 <b>∑ Certifying</b>	Physician: To the best	of my kno	wledge, dea	th occurred at the ti	me, date and place	e, and due to the	cause(s) and	manner as	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Ex	taminer: On the basis of and manner st	of examina	ition and/or i	nvestigation, in my	opinion, death occu	rred at the time,	date and plac	e, and due t	o the cause(s)
	Vithi Vithi Com	Ž	29b. Signature and tipe of certifier	19. 6x	10.9		29c. Licens			29d. Date sign		Day, Year)
	. ^		- Jun	HAT A!	The	۷	D335	54		May 5,	2009	
	20		30 Name and address of person with the Yero, III	no completed cause of c M.D. 5410	death (Iten 0 Con	n 23a) (Type, nectio	cut Ave,	NW Washir	gton, D	C 20015	5	
	Sta	te	31. Date filed (Month, Day, Year)		rar's Signa	ture	1.01					
	Registr	ar	MAY 08	2009 Dene	m,	1. 14	arkel	•				

09-02953 William Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

mani somison		For State	Certif	ficate of	Death			Reg. No	. 4	009	140
Physicia		egistrar . Decedent's Name (First, Middle,Last)					Month	of Death Day	Year	3. Time of D 1839 h	
edical Examii	ner	William Johnson						13, 2009	- Ocuptu of		
	4	a. Facility Name (if not institution, give stree	t and number)	4	b. City, Town, or I	_ocation of De	eath	14	c. County of	Death	
		Johns Hopkins Hospital	_		Baltimore					G Birthalago (State	205
Funeral		. Social Security Number unk6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24	Min			<ol> <li>Birthplace (State Foreign</li> </ol>	unk unk
Director	1	1 <sup>X</sup> M	82	Yrs.	Months Days	Hours	Jui	ne 21,	1926	Country)	
	-	Jsual Residence of Decedent				11_					Oli Linite
any		10a. State 10b. County	10c. City, To	own or Locati	on					10d. Inside	-
× 1		MD	Ва	ltimor	ce					1 X Yes	2No
Aaryland 28a-f show 1 at once.	휘	10e. Street and Number			10f. Zip Code			10g. C	itizen of Wh	at Country?	
th the Maryland  23a or 28a-f sho	Director					01015			TICA		
3a of		1400 E. Madison St	Was Decedent Ever in U.S.	1 12 1/40	a Docodent of His	21215	CSpecify Ye	es or No-	USA 14. Race	- American Indian, I	Black,
h wit	Funeral		was Decedent Ever in U.s. Armed Forces?	inkt 13. Wa	es, specify Cuban	, Mexican, Pu	uerto Rican,	etc.)	White	, etc.	
deatl or ite	[5]	1	Yes 2 No		V 2 TT No	specific			Specify:	1.11-	
after al".	<u>a</u>	3 Widowed 4 Divorced If Yes	ies:	1 Deserted	Yes 2 X No		d of work dor	10 m le 16t		black siness/Industry	unk
ours		15. Decedent's Education (Specify only high		during m	ost of working life	. DO NOT use	e retired)	ulik			dinc
72 h	ompleted	Liomontary, corrections (1912)	College (1-4 or 5+)					i			
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5-0 led w tygic othe	ပို	17. Father's Name (First, Middle, Last)			unk	10.Notrier 5 i	Valle (Filot,	1431040101111010			unk
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica	B			Tree Marie	- Address (Steel	- A d Niumbe	or Pural Pr	oute Number	City or Tow	n, State, Zip Code)	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 77 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	ို	19a. Informant's Name/Relationship (Type,	Print )	1							
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Heath and Mental Hygiene, fant: (I item 27 is marked other than or other traumatic event, the Medical		O.C.M.E.		1	Penn Str		Date	re, MD	2120 c. Location	City or Town, State	e
e, lend Heal		20a. Method of Disposition  1 Burial 2 Cremation 3 F		rematory or of	sition (Name of ce ther place)	inletery,	Date	-			
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Baltimore, permit Pages 1 a Department of He Important: If ite	1			22.	Name and Addres	s of Facility		5 1.1	Doltim	ore Stree	a t
Baltimore permit Pages 1 Department of F Important: If injury or other	i i	21. Signature of Funeral Secretic Secretary	de, Director	D.	ate Anac	Omy DO	1201	W C	Darcin	iore bere	
Physician	H	23a Part I. Enter the disease, or complicati	ons that caused the death.	Do not enter	the mode of dying	, such as car	diac or respi	ratory arrest,	shock, or he	art Approxi	mate Interval n Onset and
r ilysiciali Lai al		failure. List only one cause on each II	<sup>ne.</sup> heroscleroti							1	Death
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	ia l		to (or as a consequence of	):							
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated									
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Records, P.O. Box 68760,  The law requires that the death certificate be executed cate that been signed by the attending physician and news. 5 should be detached for use as the burial - transit	a E	d	23a,PII	,27,pe	erME, g8	<del>)</del> 1 5/1.	1/09 T	T			
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760, cate be physical	₽	n i Liu iLL	3c. If yes, outcome of pregi		3	Ectopic	pregnancy	1	Month	Day	Year
68 ertifi ding	ä	23b. Was decedent pregnant in the past 12 months?	Live birth  Pregnant at time of de		Fetal death 3 Other (Specify)	Lotopio	program,	-			
Box 687 e death certific the attending p	sic	1 Yes 2 No 9 Unknown		5 [	other (Specify)						
he de	Physician	Part II. Other significant conditions co		esulting in the	e underlying cause	e given in Par	t I.			tribute to the cause	
that t	वि	Chronic obstruct:						1 Yes	2 No	Probably 4	✓ Unknown
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e lav	Completed							✔ Yes 2		1 Yes	2 No
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ita sician is cer	Be	examiner? Hos	oital: 1 ✔ Inpatient 2	ER/Outpatie	ent 3 DOA	Other <sub>4</sub>	Nursing Ho		esidence 6		
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ding h	5	1 X Natural 5 Pending	(Month, Day, Year)		1	Yes 2	No				
SiO Viter deat	g	2 Accident Investigation	28e. Place of Injury - At h	nome, farm, st	treet, factory, offic	e building, etc	c. 28f.	Location (St	reet and Nur	nber or Rural Route	Number, C
Division of Vital Records, P.O. rate of vital Records, P.O. are after death are death and piecete has been signed by Jud. in with a financial director mass 2 should be deated	ĮĘ	3 Suicide 6 Could not be determined	(Specify)				1	or Town, Sta	ate)		
Division of Vital Records, P.O. B vital Records, P.O. B within 24 hours after death.  The Funcar Director: After this certificate has been signed by the control of the former of the fo	Certification:	4 Homicide	<u> </u>	tae death ca	curred at the time	date and pla	ace, and due	to the cause	(s) and man	ner as stated.	
ie 110 n 24 j	<u>8</u>	(Check only one) 2 Medical Examiner:0	to the best of my knowled to the basis of examination a	and/or investi	gation, in my opin	ion, death oo	curred at the	time, date a	nd place, an	d due to the cause(	s)
To th within	Medical	2 Medical Examiner.	nd manner stated.			ense number			29d. Date s	gned (Month, Day,	Year)
	Σ	29b. Signature and title of certifier				C.M.E.			April 14,	2009	
		anel				U.1VI.L.					
	1	30. Name and address of person who cor	npleted cause of death (Iter	m 23a)			04004				
		Ana Rubio MD. Assistant	Medical Examiner	111 Peni	n Street, Balti	more, MD	21201				
	State	31. Date filed (Month, Day, Year)	3. Registrar's Signa	ture	41						
	istra		anewa &	. ADa	Med						

# Maryland 21215-0036 2009 Baltimore,

the death certificate be executed

	9.	
EDWARD KELLY	Division of Vital Records, P.(	
	9	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 1 1 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 April 26, **Physician** 12:20 PMM Edward John Kelly /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Timonium Stella Maris | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 25, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1**X** M 2 □ F 218-07-5869 87 1921 Maryland Director Usual Residence of Decedent the Maryland 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. MD 1 ☐ Yes 2√∑ No Harford Fallston Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2128 Buell Drive 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
12 Yes 2 □ No If Yes, Give Year or Dates: 136–42 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 X No Specify Specify: White <u>ک</u> 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) warehouse worker grocery store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Kelly Antoinette Melichar ೨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2128 Buell Drive Fallston, MD Cathy Rumbley/daughter 21047 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Warder 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Inter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fi disease or condition resulting in death) mediate Cause (Final a. PROSTATE CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of): the attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t I be detach that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aw autopsy The 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I or Attencafter death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospital 24 hours a e Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely oneX Nurse Practitioner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and tipe 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 08 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Joseph Walter Kaminski 2009 5:50 P. May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Hospice Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 基M 2 ☐ F 217-03-2229 100 June 1908 Balt., Maryland 16, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10h. County 10a. State 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the McCical Event in ust be notified at Rosedale Maryland Baltimore 1 ☐ Yes 2 No Director United States of America 10f. Zip Code 10e. Street and Number 21206 5636 Daybreak Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Public Schools Bindry Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Kolodziej Joseph Kaminski ပ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau Mrs. Marie C. Kaminski/ wife 5636 Daybreak Terrace Rosedale, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVANS Function
Chapel Function
Chapel Function 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) eacerd Artefratives Funeral & Cremation Ctr., P.A. 21. Signature of Funeral Service Licenses 2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC CARDIOMY OPATHU UMARS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 000 e Hospital or Attending Physician: 24 hours after death.
9 Funeral Director: After this certifics letely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HCSPLE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAN 7,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NEUALIES ST, SUITE 209 BALTIMORE, MD 21204 DANKLIE DOGERMAN, MO

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 8 2009

32 Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Day **Physician** 20°0°9 2:50 а м G. Lincoln 3 Warren /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Gardens N/A Baltimore If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year)
4-25-1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 XM 2 ☐ F 86 VA Director 236-26-2613 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mental Hygiene. Important: If the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Nexical Eximiner must be notified at any injury or other traumatic event, Ite Nexical Eximiner must be notified at 1 Ves 2 No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1301 Cliftview Avenue 21218 Funeral U S Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 No 1 □Yes 2¶ No ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2\_years Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufus Lincoln 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vergie Lincoln-Wife 1301 Cliftview Avenue Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 5-8-2009 Owings Mills, MD 21. Signature of Freeral Service 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD21202 23a. Part1. Ent., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ULMONARY 13/2051s disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 124 hours after death.

Per Funeral Director; A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHETERIAL Rs PHILADEUPHA 9106 31. Date filed (MoNth, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8:49 Naomi ambert lav 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memoria Kaltimore last birthday) Yrs. 7. Age (In yrs. If I Ind Date of Birth 2 29/359. Birthplace (State or Foreign (Month, Day, rear) **Funeral** 1 ☐ M 2 F Months Days Hours Min Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show er than "natural", or items 23a or 28a-f shor Director 1 Yes 2 □ No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian 11. Marital Status Black, White, etc within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify ð 3 
Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oth Health and Mental Hygir tem 27 is marked other 17. Fether's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname Be ould be f Mental I Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) Number, City or Town, State, Zip, Code) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any Injury or other trau Konald Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 00 21. Signature of Funeral Service Lice 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appro mate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 mon /Medical Due to (or as a consequi Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and certificate be execu Box 68760, Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) □Yes 2 P.0. the Nο detached 9 Unknown 9 Unknown á signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Did tobacco use contribute to the cause of death? Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 s autopsy perform certificate 2 □No Division of Vital 1 ☐ Yes 2 [ 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[ ဥ 1 🗀 Yes 1 Inpatient ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) **2**8b . Time of Certification: 28d. Describe how injury occurred After 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury thours after death. uneral Director: Afely filled in by the fur 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 > ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address, of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar sistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:30 AM belman - (Ina 6 May 2004 /Medical 4a. Facility Name (If not institution, give street and number)
SEASON'S HOSPICE @ NORTHWEST HOSP. 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE 8. Date of Birth MAY 15, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Year)925 Months Days Hours Min. 1 □ M 2 V F ŔŰŜŜIA 214-41-4093 83 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10d. Inside City Limits 10c. City. Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Pacifical Evantment with be notified at optice. Director MD BALTIMORE 1 ☐ Yes 2√☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6958 BROOKMILL ROAD #1D 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc 1 ☐Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 🙀 Married Maryland 21215-0036 1 □Yes 2 No WHITE Specify ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KONSTANTIN KOVALEV UNKNOWN UNKNOWN ဥ 19a. Informant's Name/Relationship (Type. Print) VLADIMAR DAVYDETS/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9630 MORNING LEAP TERRACE COLUMBIA, MD 21046 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 3 Removal from State COLUMBIA MEMORIAL PK 05/07/2009 CLARKSVILLE, MD 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD-PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or com shock, or heart failure. List only that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e on each line. Immediate Cause (Final **Physician** . Hacerebral remorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been si 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2K No After this certificate 1 ☐Yes 2 ☐No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☑ Natural 2 ☐ Accident death. 1 ☐Yes 2 ☐ No 24 hours after deatl Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Hospital or Attending within 2 To the the

> State Registrar

one)

29b. Signalule and title of certifie

92 32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DUU53337

Sute 200 Keisterstown

29d. Date signed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygierie

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Elizabeth Madison Grace 1:45 AM 2009 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore City FutureCare Canton Harbor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Year Months Days Hours 1 M 2 ST F Yrs. Director Aug. 27,1919 Pennsylvania 89 213-12-2185 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes X No Dunda1k Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 3207 McShaneway Items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lile. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Roberts William F. Amann ျှ 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 3207 McShaneway Dundalk, Maryland Ms. G. Claudia Madison 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 5/9/2009 Baltimore, Maryland <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. ( min 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician PULMONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 DXNo 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an TO THRIVE certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending Pl
 Abours after death.
 Funeral Director: After the Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) MCRNP and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R125508 alv, Sznr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNE L. VILLANUEVA, CRIMP 2017 503 Bout more, 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Doroth  a. Facility Name (I)  Bon Seco  Social Security N 220-30-2  Jsual Residence of 0a. State  MD  Oe. Street and Nur 2929 W. 1  1. Marital Status 1 Never Marri 3 Widowed  (Spec	mosher  21 Marrie  Mosher  2 Marrie  15 Decedent  10b County	Stree	L 2 <b>∑</b> F 7.	Age (In yrs. 74	Yrs ty, Town or <b>altim</b>	If Under Months  Location  Ore	3altimo	ore ore inder 24 Hrs. ours Min.	8. Date of B (Month, L)	irth Day, Year 1934	c. County of D	Birthpl Count V	A. Inside C	or Fore
Social Security N 220-30-2  Jsual Residence of 0a. State  MD  0e. Street and Nur 2929 W. 1  1. Marital Status 1   Never Marri 3   Widowed  (Spec	Decedent 10b. County  Mosher  ed 2 Marri 4 Divorced 15. Decedent ify only highes ndary (0-12)	Stree	2 K F  7. 2 K F  Nas Decedermed Force I Tyes 2	74  10c. Cil  Ba	Yrs ty, Town or <b>altim</b>	Location  10f. Zip	1 Year If U Days Ho	Inder 24 Hrs.	(Month, E	1934 1934	7	V 10	ny) A od. Inside C 1 X Yes	ity Lim
July July July July July July July July	Decedent  10b. County  her  Mosher  ed 2 Marri 4 Divorced  15. Decedent ify only highes  ndary (0-12)	Stree	Nas Decederated Force 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10c. Cii  Ba	ty, Town or	Location  ore  10f. Zip	Code	ours Min.	11/29/	1934		10	A. Inside C	-
0a. State  MD  0e. Street and Nur  2929 W. 1  1. Marital Status  1 Never Marri  3 Widowed  (Spec	nber Mosher  ded 2 Marri 4 Divorced  15. Decedent ify only highes dary (0-12)	ied 1	Was Decede Armed Force I ∐Yes 2 fYes, Give	Baent Ever in U	altim	ore				10~ 0			1 <b>X</b> Yes	
0e. Street and Nur 2929 W. 1  1. Marital Status 1 Never Marri 3 Widowed (Spec	Mosher  ed 2 Marri 4 Divorced  15. Decedent ify only highes indary (0-12)	ied 1	Was Decede Armed Force I ∐Yes 2 fYes, Give	ent Ever in U		10f. Zip				10~ 0		Court		2
2929 W. 1  1. Marital Status  1  Never Marri  3  Widowed  (Spec	Mosher  ed 2 Marri 4 Divorced  15. Decedent ify only highes indary (0-12)	ied 1	Was Decede Armed Force I ∐Yes 2 fYes, Give	No No	6 4									
1 Never Marri 3 Widowed  (Spec	4 Divorced  15. Decedent ify only highes ndary (0-12)	ied 1	Armed Force I □Yes 2 fYes, Give	No No	0 1		21216			ivy. C	itizen of What <b>USA</b>	Couri	ıyr	
3 ☐ Widowed  (Special Special	4 Divorced  15. Decedent ify only highes ndary (0-12)	s Educatio	f Yes, Give	No	.5.	3. Was Deced If Yes, spec	ent of Hispan	nic Origin? (Spexican, Puerto	pecify Yes or N	0-	14. Race - A Black, W			
Elementary/Seco	<i>ify only highes</i> ndary (0-12)	's Educatio				1 □ Yes 2		ecify:			Specify:		ack	
		u grade coi	n mpleted)		[ (G	cedent's Usua ive kind of wor e. DO NOT us	k done durind	g most of worl	king	16b.	Kind of Busine	ss/Ind	ustry	
	Εħ		College (1-4	or 5+)		ursing		tant		Но	spital			
7. Father's Name	First, Middle, L	Last) Un	ık.						e (First, Middl	e, Maide		-		
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		. — по	isbang	20b. F	Place of Di	sposition (Nam	ne of	treet,						
			oval from Sta	ate Lo	udon	Park	ner place)	05/0	5/2009	Bal	ltimore	, M	D	
				- DV7D		22. Name an	d Address of	Facility Vau	ghn C.	Gre	ene Fu	ner	al Se	rvi
resulting in death) Sequentially list contains, leading to middle cause. Enter Unde Cause (Disease or Intal mittated events resulting in death) I	nditions, mediate rlying injury	a	Due to (or	chro	quence of): onic ( quence of):									
23b. Was decedent in the past 12	months?		1 ☐ Live bir 4 ☐ Pregna	th 2 ☐ Feta nt at time of	al death						23d. Date of Month			Year
Part II. Other signif	icant conditio	ons contribu	uting to dea	th but not res	sulting in th	e underlying ca	ause given in	Part I.						
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examiner?		Hosp	ital: 1 🗀 Inc	natient 2	1 FB/Outna	tient 3 □ DC	Other:				6 □Other /	Specif	v)	
27. Manner of Deat	h		8a. Date of	Injury	28b. Tim							<u>opoon,</u>	·/	
2 Accident 3 Suicide 4 Homicide	investig 6 ☐ Could n	gation				M	1 □ Yes	2 □ No				r Rura	l Route Nu	m <i>b</i> er,
29a. Certifier (Check only one)			On the bas	is of examin										(s)
29b. Signature and	title of certifier	r		k				mber		29d. [	Date signed (A	fonth,	Day, Year)	
	100		W	M	_	W) I	13619				5-8-	0	9	
2 1 iden Si contre	Eugene  Da. Method of Disk  1	Eugene McNeil  Oa. Method of Disposition  1	Eugene McNeil - Hu  Oa. Method of Disposition  1	Oa. Method of Disposition  1	Eugene McNeil - Husband  Oa. Method of Disposition  1	Eugene McNeil - Husband  Da. Method of Disposition  1	Sequentially list conditions and search line should great the death of the past 12 months?   Security of the past 12 months of the past 12 month	Eugene McNeil - Husband  10a. Method of Disposition  1	Pal. Informant's Name/Relationship (Type, Print)    Rugene McNeil - Husband   2929 W. Mosher Street and Number or Ru 2929 W. Mosher Street   2929 W. M	Ba. Informants Name/Relationship (Type. Print)  Eugene McNeil - Husband  Da. Method of Disposition  Light of Disposition (Name of Committed Committed)  Light of Disposition (Name of Committed)  Light of Disposition (Name of Committed)  Light of Disposition (Name of Committed)  Light of Disposition (Name of Committed)  Date Committed (Disposition (Name of Committed)  Date (Date (Disposition)  Date (Date (Disposition)  Date (Date (Disposition)  Date (Date (Disposition)  Date (Date (Disposition)  Date (Date (Disposition)  Disposition (Name of Committed)  Disposition (Name of Disposition)  Disposition (Name of Committed)  D	Das Method of Disposition  Das Method of Disposition  Date   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Disposition (Name of camples)   20c. Place of Place of Place of Coronary   20c. Place of Disposition (Name of camples)   20c. Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Place of Disposition (Name of Camples)   20c. Place of Pla	19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State   2929 W. Mosher Street, Baltimore, MD 2   2920 W. Mosher Street, Baltimore	199. Informant's Name/Relationship (Type. Print)  Eugene McNeil — Husband  18 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip  2929 W. Mosher Street, Baltimore, MD 2121  200. Leatinore, MD 2121  200. Date of Coc. Leatinore, MD 2121  201. Date of Coc. Leatinore, MD 2121  202. Name and Address of Facility Vaughn C. Greene Puner.  18 Spatial of Chemical Service Lease  19 Vaughn C. Greene Puner.  19 Vaughn C. Greene Puner.  19 Vaughn C. Greene Puner.  19 Vaughn C. Greene Puner.  19 Vaughn C. Greene Puner.  19 Vaughn C. Greene Puner.  19 Justice of Puner of State of Puner is the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender of the mode of dying, such as cardiac or respiratory arrest, sender or spiratory arrest, spiratory arrest, sender or spiratory arrest, spiratory arrest, spiratory arrest, spiratory arrest, spiratory arrest, spiratory arrest, spiratory arrest, spiratory arrest, spiratory arrest, spiratory arrest, spiratory arrest, spiratory arrest, spiratory arre	Section   Sect

Physician /Medical Examiner

Physician

/Medical

Completed by Funeral Director

Be

2

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Exp. input. set be netfilled at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	shock, or heart fairle. List only	one cause on each line.	mode of dying, such as cardinc or res	piratory arrest,	interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. Perhinsen's Dis	eese.		Oriset and Death
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b			
ical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy r (specify)	23d. Date of de Month	elivery Day Year
ted by Ph	Part II. Other significant conditions of	contributing to death but not resulting in the underlyi	ng cause given in Part I.	23e. Did tobacco use contribute t	
Complet				autopsy prior to performed? death?	utopsy findings available completion of cause of s 2/100
Be	25. Was case referred to medical examiner?		26. Place of Death (Chi	eck only one)	
	examiner? 1 ☐ Yes 2. ☑ No	Hospital: 1 inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Spe	ecify)
Medical Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work?	Describe how injury occurred	
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edical	29a. Certifler (Check only one)  Certifying Principle (Check only one)	hysician: To the best of my knowledge, death occu miner: On the basis of examination and/or investige and manner stated.	rred at the time, date and place, and dation, in my opinion, death occurred at	due to the cause(s) and manner a t the time, date and place, and du	as stated. e to the cause(s)
Ž	29b. Signature and title of certifier		29c. License number	29d. Date signed (Mon	th, Day, Year)
				60	00.50

State Registrar

5310

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 08 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Marylands Departments and Mental Hygiene 2 () () 9 14888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** 8. Eugene H. McIntyre, Jr. April 12:45 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges County Hospital Prince Georges Montgomery 8. Date of Birth 12-11-1927 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 215-24-7693 1 □ M 2 □ F 81 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Itan Worlden Examinant. Maryland Anne Arundel 1 ☐ Yes 2/□X/No Directo Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2854 Jessup Road 20794 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Ft No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Scherers Butcher Shop Butcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene H. McIntyre, Sr. Gertrude Proschold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella McIntyre/Wife 2854 Jessup Road, Jessup, Maryland, 20794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 4/14/2009 | Elkridge, MAryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 21. Signature of Funeral Service Licensee 7250 Washington Blvd, Elkridge, Md. 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 3Days Actute Respiratory Failure /Medical Due to (or as a consequence of): Examiner 3 Days Spontaneous Pneumo Thorax Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed 10 Years Chronic Obstructive Lung Disease attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 📆 Probably 4 ☐ Unknown Completed Hypertension 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 🗓 No 1 ☐ Yes 2 🛛 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭Wo tk Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2. 29d. Date signed (Month, Day 14709/2009 29b. Signature and title of certifier 29c. License number 16273

Registrar DHMH 17 Rev 1/2001 Revathy Murthy, 6130 Landover Rd, Cherverly, Maryland 20875 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 08 2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 520 FM **Physician** Moreland MAY 10 serh 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Min. Days Months Hours 1**X** M 2□ F 79 03/15/1930 MD Director 218-28-4196 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be retified at 1 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 USA 6300 Red Cedar Pl. Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ⊠ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No þ 3 ☐ Widowed 4 ☑Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State of Maryland s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than "other traumatic event, the Mar Elementary/Secondary (0-12) College (1-4or 5+) Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Mary Theresa Dailey Alonzo Gordon Moreland 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Calvin B. Slaughter/Partner 6300 Cedar Pl. Baltimore, MD 21209 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State May Beltsville, Maryland Chesapeake Crematory Inc. 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ventricolar **Physician** hour /Medical Due to (or as a consequence of): Examiner 12 nonths Caroner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? ichetes 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **₽**No 2 ☑ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient Certification: To funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after death Funeral Director: the 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical опе and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 29b. Gignatui MM D38675 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 301 ST PAUL PLACE #804 BALTIMORE MO 21202 31. Date filed (Month, Day, Year) Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** nearthur /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Nursing Heights Rehab 8. Date of Birth Month, Day, Year) Feb. 28, 1951 9. Birthplace (State or Foreign Age (In yrs. last bi **Funeral** 218 58 4969 58 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Baltimore 1X Yes 2 □ No Director Md. 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 1715 E. Eager St. Apt. 324 21205 USA Funeral 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No black Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel llth laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James McArthur Jean Howe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1715 E. Eager St. Baltimore, Md. 21205 Apt. 324 Marshia Mason-McArthur (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1.
Department of He
Important: If Iten
any Injury or oth 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory May 13,2009 Balto, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto,Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sheek, or nearl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 🗆 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant,conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O.

within 72 hours after death with the

Baltimore, Maryland 21215-0036

'natural", or items 23a

and Mental Hygiene.

Health Item 27

burial-transit certificate be executed attending physician and for use as the burial-trar been signed by the a should be detached f this To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

State Registrar

Medical

SANDHU 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

MAY 08 2009

HYJICIAN 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

1940 W.BALTIMORE IT, BALTIMORE MP 2,223 32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D57543

29d. Date signed (Month, Day, Year)

09-03611 Neil McClain Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		2204 Telegraph Ro		17	Age (In yrs	loct hirth	nday)	If Under		If Under	24Hrs.	8. Date of	Birth(MN	N/DD/YYYY)	9. Birth	place (State or
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygeine House the shad marked other than "natural", or items 23a or 28a-f shootraumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2					1	es, specify	Cuban, X No	Mexican, specify:	Puerto F	Rican, etc.)		Specify:	Whi	
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ID 21215-0036 should be filed within 72 hours after and Mental Hygiers, "j's marked other than "natural", "j's marked other than "natural", mitic event, the Medical Examiner.		17. Father's Name (First, Mic	dle, Last	)					1		s Name		le, Maid	en Surname	ur	nk
2121 uld be fi Mental marked ic event,	To Be	unk 19a. Informant's Name/Relat	ionship (	Type, Print )		19	b. Mailing	Address	(Street	t and Num	ber or R	ural Route	Number	City or Tow	vn, State	e, Zip Code)
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Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum:		20a. Method of Disposition  1 Burial 2 X Crem  4 Donation 5 Other			01-1-	crema	tory or ot	sition (Nam her place) unt			5-7	7-200				re, MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		21. Sign sure of Funeral Se	vice Lice	nsee	le .		. 26	33 S.	. Co	onkl	ing	st.	Ba.	ltimo	re,	
Physician		23a. Part I. Enter the diffeating failure. List only on the	e, or com	plications that car ach line.	used the de	ath. Do n	ot enter t	he mode o	f dying,	such as c	ardiac o	r respirator	y arrest,	shock, or he	eart .	Approximate Inter- Between Onset at Death
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d Sit	Examiner	cause. Enter Underlying C (Disease or injury that initial events resulting in death)	teo	Due to (or as a	consequen	ce of):										
760, icate be executed physician and the burial - transit	Medical E	1		AMENDED												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and the control of the After this certificate has been signed by the attending physician and control of the control of the After the forest director man 2 should be delarched for use as the burial. Trans	cian/Med		t in the	23c. If yes, c			2 F	etal death		Ectop	ic pregn	ancy		23d. Date Month	of delive	pry Day Year
D.O. Box 687 that the death certification ned by the attending detached for use as it	Physician	1 Yes 2 No 9		9 UIKIO			on in the	underlyińs	Cause	given in P	Part I.	23e.	Did toba	cco use cor	ntribute 1	o the cause of death?
, P.O. rres that the signed by	۾	Diabetes Mellitus		s contributing to	death but	not result	ing in the	didenying	y cause	giveniii		1.1		2 No	3 Pr	obably 4 🗸 Unknow
cords, law require has been sig	Completed												Was an autopsy perform	ed?	prior to death	autopsy findings avail o completion of cause
tal Reco	Re Com								26 Plac	e of Deat	h (Check	1 v	Yes 2	No	1 🗸	Yes 2 No
/ital ysician:	a a	examiner?		Hospital: 1	Inpatient	2 ER	/Outpatie	nt 3 [	DOA	Other,	_	ing Home		esidence 6		ner: Scene
n of V ding Phys	T. C		Pending		of Injury n, Day,Year)	281	b. Time o	f Injury		jury at Wo Yes 2		28d. Des	cribe ho	w injury occ	urred	
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director; After this certificate has been significant in the funeral circuit in the funeral director.	Certification:	2 Accident 3 Suicide 6	Investig Could n	ation 28e. Plac	e of Injury	- At home	, farm, st	reet, factor	y, office	building,	etc.		ation (Strown, Sta		mber or	Rural Route Number,
Le Hospita				sician: To the besiner:On the basis		owledge, o	death oc	curred at th	ne time, ny opinio	date and p	place, ar occurred	nd due to the d at the time	e cause e, date a	(s) and man	ner as s id due to	tated. the cause(s)
To the Within	Modical	29b. Signature and title of		and manner s	stated.				9c. Lice	nse numb				29d. Date s	igned (i	Month, Day, Year)
		30. Name and address of	lor	Poul	se of death	(Item 22	a)		0.0	C.M.E.				May 6, 2	.009	
12	/	Laron Locke MD	Ass	sistant Medica	al Exami	ner 1	111 Pe	nn Stree	et, Bal	timore,	MD 21	1201				
Reg	Stat istra	. 24 K V (	) 8 2	009 32.	egistrar's S	ignature	6	allad								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

		or State	State	of Maryland	Certifi	icate of	Death		Reg.	No. 2	009 14	
Physician/	1.	istrar Decedent's Name	(First, Middle,Last	)					2. Date of Death  Month D	ay Year	3. Time of Death 0920 hrs	
Examiner				John Robe			b. City, Town, or Lo	cation of Death	April 27, 200	4c. County of Dea	ath	
	4a	Facility Name (if 4464 Regalv	not institution, give	street and number	er)	[ ]	Burtonsville			Montgomery		
uneral	5.	Social Security Nu		x 7	Age (In yrs. last	birthday)	-	If Under 24Hrs.	8. Date of Birth (	MM/DD/YYYY) 9. I	Birthplace (State or eign	
irector		280-62-234		M 2 F	48	Yrs.	Months Days	Hours Min.	09/30/19	960	Country) Ohio	
*	_	ual Residence of	Decedent 10b. County		10c. City. To	wn or Location	on				10d. Inside City Limi	
ow any					100, 219,			onsville		1 Yes 2 X No		
28a-f show d at once.		laryland le. Street and Nun	Montgou	ery			10f. Zip Code	MSVIIIC	109	. Citizen of What C	ountry?	
in the Maryland 23a or 28a-f sho notified at once.	"		egalwood Te	rrace			20	0866			i.A	
s 23a e noti	11	Marital Status	egalwood le	12. Was Deced	ent Ever in U.S.	13. Wa	s Decedent of Hispa es, specify Cuban, I	anic Origin? ( Sp	ecify Yes or No- Rican, etc.)	14. Race - An White, etc	nerican Indian, Black,	
should be filed within 12 hours after death with the Maryland and Mental Hygiene and Mental Hygiene "natural", or items 23a or 28a-f sht ratic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1	X Never Marrie	ed 2 Married	Armed Forc	2 No				, , , , , , , , , , , , , , , , , , , ,	Specify:	Cavagaian	
ral", o		Widowed		If Yes, Give Year 1 or Dates:			Yes 2 x No t's Usual Occupatio		work done	16b. Kind of Busine	Caucasian ss/Industry	
Examined the control of the control		15. Decedent's Ed Elementary/Seco	lucation (Specify o	College (1-4		during m	ost of working life.	OO NDT use ret	red)			
within 72 hour giene. Medical Exan		Elementary/Seco	indary (0-12)	4	0.01)	In	telligence	Analyst			overnment	
ed with lygiene other the Me	1	7. Father's Name	(First, Middle, Last	)			18	3.Mother's Name	e (First, Middle, M	aiden Surname)		
d be filed within 72 hours are dental Hygiene.  narked other than "natural", event, the Medical Examiner  BE Completed by				enry Plude			g Address (Street		Catherine	Ann Ries	tate Zin Code)	
is mai	1		me/Relationship (			l				jer, Gity or Tomi, e	, L. P. 37 7	
nd 2 sh alth an m 27 auma	L	George Oa. Method of Dis	H. Plude -	Father	20b. Pla	ace of Dispos	Ward Road, sition (Name of cem	etery,	Date Date	20c. Location - Cit	y or Town, State	
es l ar of Hec If ite her tr	1	Burial 2	X Cremation 3	Removal from	m State cre	ematory or ot	her place)	ļ	100 10000	Proptrood	, Maryland	
Pagiment tant:	k	Donation 5	Other Specification	/:	↑   Ft.	22	Crematory Name and Address	of Facility	/08/2009		, Maryraid	
pormit Pages I and 2 should be filed within 73 pepartment of Health and Mental Hygiens Important: If tiem 27 is marked other than injury or other traumatic event, the Medical To Be Comple	Т.	LIGAT	1,000 1	10 40	XQ.	M H	ines-Rinald 1800 New Ha	i Funeral	lvenue. 51	ver Spring	, Maryland 209	
nysicían	2	3a. Part I. Inter the	ne disease, or com	plications that cau	used the death. I	Do not enter	the mode of dying,	such as cardiac	or respiratory arre	st, shock, or heart	Between Onset	
<b>1</b> edical	1	failure. List or mmediate Cause	nly one cause on e	Hyperte	nsive a	theros	clerotic	cardio	vascular	disease	Death	
aminer		or condition resulti		Due to (or as a	consequence of)	:						
		Sequentially list co		Due to (or as a c	consequence of)	1:						
air a		cause. Enter Und Disease or injury	erlying Cause									
ed nsit	Ş   .	events resulting in	death) Last		consequence of)	):						
The law requires that the death certificate be executed reate has been signed by the attending physician and page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 2 should be detached for use as the burial - transit page 3 should be detached for use as the burial - transit page 3 should be detached for use as the burial - transit page 3 should be detached for use as the burial - transit page 3 should be detached for use as the burial - transit page 3 should be detached for use as the burial - transit page 3 should be detached for use 3 should be 3 should be detached for use 3 should be detached for use 3 shou	5	X UNPENDE		AMENDED	23a,27,	perME	, g891 5/	11/09 T	Г			
te be execut nysician and burial - tra		F FEMALE:			outcome of pregr	nancy				23d. Date of de		
e death certificate the attending phy ed for use as the b	2	3b. Was deceden past 12 month	t pregnant in the	1 Live bi			etal death 3	Ectopic preg	nancy	Month	Day Year	
ath ce or use	3		No 9 Unknow	7	ant at time of dea	ath 5 (	Other (Specify)					
the de	Physiciani	Part II. Other sign	nificant condition			esulting in the	underlying cause o	given in Part I.			ute to the cause of death	
gned le deta	<u>[</u>								- 12022		Probably 4 V Unknown	
equire									24a. Was auto	osy pri	ere autopsy findings ava or to completion of caus	
e law e has ge 2 sh	ompieted			_					perfo 1 <b>✓</b> Yes		ath? ✓ Yes 2 N	
ral or Attending Physician: The law requires that the d is after death.  The law requires that this certificate has been signed by the led in by the funeral director, page 2 should be detached	۱-	25. Was case refe	erred to medical				26.Place	e of Death (Che	ck only one)			
ysician nis cer direct	e Re	examiner?	2 No	Hospital: 1	Inpatient 2	ER/Outpatie			sing Home 5	Residence 6		
pital or Attending Physician; ours after death. teral Director: After this certif filled in by the funeral director,	- 1	27. Manner of De	ath	28a. Date (Month	of Injury n, Day,Year)	28b. Time o		ry at Work? Yes 2 No	28d. Describe	how injury occurre	u	
tendii eath. tor: /	atio	1 X Natural 2 Accident	5 Pending		250.0				28f Location	(Street and Numbe	r or Rural Route Number	
or Attene after death Director: I in by the	<b>≗</b>	3 Suicide	6 Could r	ot be		ome, farm, st	reet, factory, office	bulluling, etc.	or Town,			
filled a	ë	4 Homicide		(-,-,-,,		lae death ac	curred at the time, o	late and place,	and due to the cau	ise(s) and manner	as stated.	
184 = -	ᇹᅵ	(Check only one)	Certifying Phys	ner:On the basis	of examination a	and/or investi	gation, in my opinio	n, death occurre	ed at the time, date	s and place, and a		
the Hospita iin 24 hours the Funeral ipletely fille	<u> </u>		Medical Exami	and manner s	stated.			se number		29d. Date signe	ed (Month, Day, Year)	
To the Hospital within 24 hours a To the Funeral Completely filled	Medical Certification:			and manner s			1					
To the Hos within 24 h To the Fun completely	Medic		nd title of certifier	and manner s			0.0	.M.E.		April 28, 20	09	
To the Hosy within 24 hosy To the Fun Completely	Medic	29b. Signature at	nd title of certifier	`	use of death (Iten	n 23a)				April 28, 20	09	
To the Hosy within 24 hosy completely	Medic	29b. Signature at	nd title of certifier	`	ise of death (Iten	n 23a) 111 Penr	O.C		201	April 28, 20	09	
To the Hosy within 24 ho To the Pun To the Pun completely		29b. Signature at 30. Name and ac Ana Rubic	nd title of certifier	ho completed cau	ise of death (Iten Examiner teg strar's Signat	111 Penr			201	April 28, 20	09	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** JOHN CALVERT PROVENZA MAY 2009 5:40 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CITIZENS CARE CENTER HAVRE DE GRACE HARFORD 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F Months Days Hours Director 214-12-0941 4/7/1922 MARYLAND 87 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland inent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, Ir. Profect Train in the land in Alfa of any or other traumatic event, Ir. Profect Train in the land in Alfa of the traumatic event, Ir. Profect Train in Control of the traumatic event, Ir. Profect Train in Control of the traumatic event, Ir. Profect Train in Control of the train in Alfa of the 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 🛣 No Director MD HARFORD WHITE HALL 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5015 NORRISVILLE ROAD 21161 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WELDER STEEL 12TH GRADE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH PROVENZA ပ MYRTLE CALVERT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other troops. JANET GABOR/DAUGHTER 5015 NORRISVILLE RD. WHITE HALL, MD 21161 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 5/12/2009 BALTIMORE, MD 21. Signature of Funeral, Service Licensee 22. Name and Address of Facility M01139 THE JOHNSON FUNERAL HOME, P.A. 10/100 8521 LOCH RAVEN BLVD. TOWSON. MD 23a art 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed a No 1 ☐ Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral After t 27. Manner of Death 28h Time of 28c. Injury at Natural 2 Accident 5 Pending investigation 1 □Yes the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760. P.O. Records. Division of Vital s after death filled in by To the Hospital within 24 hours a To the Funeral L

completely

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

29a. Certifier

(Check only one)

29b. Signature and title of cortifier

Mound

ONDO

30. Name and address of person who completed cause of death (Item 23a) (Type, Pri

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			1 - State Registrar			Cer	tificate of l	Death	R	eg. No. 2	009	14894
	Physicia		1. Decedent's Name (First, Middle, La.  Mitchell	Edwar	d		Paris,	Sr.	2. Date of Deat Month	05°	ž869	3. Time of Death 3. 03:00 p <sup>M</sup>
	/Medio Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Death		4c. Cou	unty of Death	ос.оо р
p. I	Francis		5603 Summerfield 5. Social Security Number 6. S		e (In yrs. last b	oirthday)	Baltimor If Under 1 Year	e If Under 24 Hrs.	8. Date of Birth	N/A	9, Birthpl	ace (State or Foreign
	Funeral Director		219-03-1872	<b>⊠</b> M 2□ F	88	Yrs.	Months Days	Hours Min.	(Month, Day, 01/21/1		Mar Mar	yland
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loc	cation				10	d. Inside City Limits
	e Mary 3a-f sh	Director	MD N/A		Baltir	nore						1 X Yes 2 No
	with th	Dire	10e. Street and Number 5603 Summerfield	Avonuo			10f. Zip Code 21206		1	0g. Citizen	of What Count Δ	ry?
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14.	Race - America Black, White, e	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is if wides Ext. vitrar must be recitived at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 [X]Yes 2 □ N If Yes, Give Year or Dates:	WWII	-	☐Yes 2X No	Specify:			ecify: Whit	
5	72 hour natural lical Ex		15. Decedent's Ed (Specify only highest gra	ducation		a. Deced	lent's Usual Occup	ation during most of worki	ina		of Business/Ind	
7	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	`life. L	OO NOT use retired OMAN	d)		Citv	of Balt	imore
ממ	e filed v other vent, ir	Be Co	17. Father's Name (First, Middle, Last,	1		1 11	JIIQTI	18. Mother's Name				
yia	ould be Menta narked	To E	Alexander Paris					Katherine				
Z	d 2 shall the and the	1 8	19a. Informant's Name/Relationship (				,	Avenue, _E			•	Code)
ָב ב	es 1 an of Hea of Hea i item 3		20a. Method of Disposition	•	20b. Place	of Dispos	sition (Name of natory or other place				ion - City or To	wn, State
Dallillio	t. Page tment tant: If		1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y)	Garde		f Faith	· · · · · · · · · · · · · · · · · · ·			more, M	
Ö	permi Depar Impor any ir once.		21. Signature of Funeral Service Licer	> Rlan		- F	. Name and Addre 305 Harfo	ord Road,	Leonard Baltimo			IC •
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	cations that caused one cause on each lir	the death. D	o not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
mining.	Physician /Medical	8 8	Immediate Cause (Final disease or condition resulting in death)	a	Cor	unar	7 Arta	tic Ster	50			Onset and Death
	Examiner			Due to (or as a	a consequenc	e of): マインタ	, Aor	tic Ster	2022			10405
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequenc	e of):	11.1	E-1:11	( E)a>			10)
	executen and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a			TARC	/- 102176	.4 (10.4			TUyrs
00/00	certificate be executed iding physician and se as the burial-transit			d								
Ď X	certific nding p	//Medical	IF FEMALE:	23c. If yes, outcome	of pregnancy					23d	. Date of delive	erv
	death	Physiciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 - Fetal dea		Ectopic pregnand Other <i>(specify)</i> _					Day Year
	hat the ed by the detache		9 ☐ Unknown  Part II. Other significant conditions of		ut not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to the	ne cause of death?
c C	quires t n signe ald be o	d by		Prostute	Cance				1 □ Y	es 2□N	No 3□ Prob	ably 4 Unknown
necords,	law rec as bee 2 shou	Completed		Colon C	in Cen				24a. Was a		24b. Were auto	psy findings available mpletion of cause of
ב ב	r: The icate h r, page								perför 1 □Yes	med? 2 █ <b>(</b> No	death?	2 No
_	ysiciar s certil	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 ER/	Outpatier	nt 3 DOA Oth	26. Place of Deat	h <i>(Check</i> on <i>ly</i> or ome 5 <b>⊠</b> Resid		Other (Specif	v)
VISION OF	ing Phy offer thi uneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28b	Time of	28c. Inju	ry at k?	28d. Describe h			
2	Nttendi death. ctor: A y the fu	ficati	2 Accident investigation 3 Suicide 6 Could not b	e 28e Place of Inju	urv - At home,	farm, str	M 1 □ eet, factory, office	Yes 2 □No	28f. Location (S	treet and N	lumber or Rura	l Route Number,
2	tal or / s after al Dire ed in b	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	,			City or Tow			
Ó	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for u	Medical	29a. Certifier  (Check only one)  1. □ Certifying Pl  2 □ Medical Example one)	hysician: To the best of miner: On the basis of and manner sta	f examination	dge, deat and/or in	n occurred at the ti vestigation, in my	ime, date and place opinion, death occur	and due to the cred at the time, o	cause(s) ar date and pla	nd manner as s ace, and due to	tated. the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier				29c. Licens		1		signed (Month,	Day, Year)
			30. Name and address of person who	Sou人mar completed cause of d	eath (Item 23a	a) (Type,	Print) 0 1	01287	0	10/1	7,0	, 00-1
			JAENGOOLMAN 7602	Below	Roll		13 4 1	timore	ND :	1125	6	
	Sta Registr	ite ar	30. Name and address of person who Jaka Good and 7602  31. Date filed (Month Pay Year)	009 2. Jegistra	ar s Signature	4	artal					_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 [] [] 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2009 1:25PM May Earl Francis Parks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Good Samaritan Nursing Center Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 07-73-4 929 79 Pennsylvania 217-24-7539 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County Baltimore Parkville Maryland 1 ☐ Yes 2 X No Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with I and of Health and Mertal Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or: Juy or other traumatic event, the Medical Examiner must be n 21234 U.S.A. 3206 E. Joppa Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Ves 2 1948-If Yes, Give 1948-Year or Dates: 1950 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance Company 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Parks Long John A. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trau Baltimore, Maryland 21234 3206 E. Joppa Road Mrs. Deborah Tracey - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 05-08-2009 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road 21. Signature Funeral Servi Lic 22. Name and Address of Facility eonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the dispase, shock, or heart faiture. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the i

altimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1)58570

05, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For Amend #30 per DVR g89191378/09p	Frtment of Health and International Partificate of Death	Mental Hygier		14896
Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death April 28	Day 2009 Year	3. Time of Death 9:30 p. M
/Medi	cal	Esther Perlis  4a. Facility Name (If not institution, give street and number)	4h City Town and acction of Dooth		4c. County of Death	9:30 p. M
Examir	ner		4b. City, Town, or Location of Death Takoma Park		ontgomery	
Funeral		Washington Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birtho	place (State or Foreign
Director		306-40-3096 1□M 2□F 88 Yrs.	Months Days Hours Min.	Dec 18,		Jersey
p >		Usual Residence of Decedent			1.	0d. Inside City Limits
sho	5	10a. State 10b. County 10c. City, Town or L				1 XYes 2 No
the M 28a-f	Director	MD Prince Georges Hyattsvi	10f. Zip Code	100	Citizen of What Cour	
with Ba or	ē	5821 Queens Chapel Road	20782		Jnited Sta	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I're Madical Examiner must be redified at once.	by Funeral		Was Decedent of Hispanic Origin? (Spirity es, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
2 hou latura	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation		Kind of Business/In	dustry
thin 7 e. an "n	pe	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	e kind of work done during most of worl DO NOT use retired)			
ed wii ygien ter th	ပ်	12 Home	emaker		Own Home	
be fill ntal H id oth even	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	den Surname)	
ould Mer narke	2	Aaron Rockoss	22220000	h Epstein		
12 sh th and 7 is n traun			ing Address (Street and Number or Ru			ŕ
1 and Heall em 2			7 Wells Parkway, U		Location - City or To	
ages int of t: If It		I Li buriai 2 Li Cremation 3 Li Removal from State 1	ematory or other place) May	5.	· · · · · · · · · · · · · · · · · · ·	
artme artme vrtan Injury		A .	Care Colorado 200		Aurora, CC	
permi Depar Impor any Ir	l l	M00982  23a. Part 1. Enter the disease, or complications that caused the death. Do not er	933 Gist Ave. Silv		l & Cremat , MD 20910	ion Ser.
Physician Medical Examiner  Care pe executed by Medical Examiner  Care percentage of the prival-transit prival-	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ve hlad fa filmlig	tien		Onset and Death
I or Attending Physician: The law requires that the death certific after death.  Director: After this certificate has been signed by the attending p. in by the funeral director, page 2 should be detached for use as t.	Physician/Me		□ Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
w requires that the de been signed by the s should be detached I	ρ	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacc	co use contribute to to	ne cause of death?
<b>hyslcian:</b> The law re this certificate has be al director, page 2 sho	Completed	Cesperalient Ince	lmentè	24a. Was an autopsy performed 1 □Yes 2 💢	? prior to co	psy findings availabl mpletion of cause of 2  No
slcian certif rector	Be	25. Was case referred to medical examiner?  1. Description: Hospital:		th (Check only one)		
nding Physath. r: After this e funeral di	ation: To	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  1 ☑ Accident Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie 28a. Date of Injury (Month, Day, Year) Injury	THE SEL DOA 4 LI NUISING H	ome 5 Residence 28d. Describe how in		(y)
tal or Attenors after deathal Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifler (Check only one)  1 Certifling Physician: To the best of my knowledge, deal check only and manner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due to	o the cause(s)
Vitl To	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			3614/		5/5/1	)9
7		30. Name and address of person who completed cause of death (Item 23a) (Type		17701 04-	11 4	Takoma Dos
<i>5</i>		Nasreen Mustafa Kango, MD Washington		I//UL CATI	OTT WAG*	Takoma Par D 20912
Sta Registr		31. Date filed (Month, Day, Year)  NAY 08 2009  33 Registrar's Signature	arker		H	D 20/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Debra Lynn Pope 1, 2009 May 12:30 p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 15610 Plaid Dr. Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 5, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Min. Hours 1958 **Director** 50 New Jersey 157-52-8369 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD Prince Georges Laurel 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 20707 United States 15610 Plaid Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within hand Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Computers Information Tech. Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Payten Joseph Pope ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any Injury or other traur 15610 Plaid Dr. Laurel, Maryland 20707 Barry Pope (son) 200. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, MD 4 Donation 5 Dother (Specify) Chesapeake Crematory 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, MD 20910 M00982 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nmediate Cause (Final **Physician** End Stage Acute Myelogenoos Leukemia Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Yr. Diabetes Type II Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner Parkinson's Yr. burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical Yr. Hypertension the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 💢 No P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Depression, Anemia page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No certificate ! 1 □Yes 1 ☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \bigveeteta Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 XXVo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After ospital or Attending I hours after death. 1 ☑ Natural 2 ☐ Accident Injury 5 Pending within 24 hours after deau..

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 4, 2009 D54749 30. Name and address of person who completed cay e of death (Item 23a) (Type, Print) 5 M.D. 801 Toll House Ave. #D-1 Frederick, MD 21701 Allen Reilly, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State

DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day, Year)
Registrar

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32. Registrar's Signature

Drum A. Agarel

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 00:60 Sidney Clay Robertson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Seasons Hospice of Baltimore Randallstown Under 1 Year | If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**™** M 2□ F 70 Yrs 10/10/1938 Director 226-50-0370 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show other traumatic event, the Medical Examiner must be notified at 1 MYes 2 □ No Director MD 28a-f Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21230 items 23a 118 East Clement St. Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: White Specify: 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Computer Science Corp Elementary/Secondary (0-12) College (1-4or 5+) Computer Programer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Allen Robertson George ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Robertson/Wife 118 East Clement St. Baltimore, MD 21230 permit. Pages 1 and Department of Healt Important: If item 2: any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M0144 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate Cancor **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Ves 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other Specify to Specify 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? After 5 Pending 1 Natural 1 ☐ Yes 2 No ours after death.
neral Director: A
filled in by the fu death. investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical and manner stated. 29c. License number 29b. Signature and title of certifie 1+45931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Menne Baltimore MD 21209 0

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Box 68760,

P.O.

Division of Vital Records,

9-02847	Dile	Please Type or Print in Black Indelible In			ole.
narles Whalen		1- For State Certificate of		vgierie Reg. f	2009 1490
Physicia	an/	Registrar  1. Decedent's Name (First, Middle, Last)		Date of Death     Month Da	3. Time of Death
edical Exami	ner	Charles W. Riley  4a. Facility Name (if not institution, give street and number)	lb. City, Town, or Location of Death	April 9, 2009	4c. County of Death
		410 York Road	Towson		Baltimore County
Funeral		5. Social Security Number un 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	I .	MM/DD/YYYY) 9. Birthplace (State or unk
Director		1 <sup>X</sup> M 2 F 59 Yrs.		Oct 3,	1949 Country)
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati	on		10d. Inside City Limits
Maryland 28a-f show d at once,	ō	MD Baltimore Tows			1 Yes 2 No
e Mary or 28a-	Director	10e. Street and Number 410 York Road	10f. Zip Code 21204	10g.	Citizen of What Country? USA
n with the Maryland ms 23a or 28a-f sho be notified at once,		11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? (Sp		14. Race - American Indian, Black,
or item	Funeral	1 Never Married 2 Married Armed Forces? unk If Y	es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.
rs after nral", miner	þ	or Dates:	Yes 2 X No specify: t's Usual Occupation (Give kind of v	ork done unk 16	Specify: white  Sb. Kind of Business/Industry unk
5 72 hou n "nat sal Exa	leted	Elementary/Secondary (0-12) College (1-4 or 5+) during m	ost of working life. DO NOT use reti	red)	, unk
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	Comple	unk unk	119 Mothor's Namo	(First, Middle, Maid	den Surnama)
nore, MD 21215-0036 ages 1 and 2 should be filed within 7 nt of Health and Mental Hygiente. It Iften 27 is marked other than other traumatic event, the Medica	Be C	17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	(Filst, Middle, Mak	den Surname) unk
21) hould be nd Men is mar	Tol		Address (Street and Number or F		
and 2 sho ealth and tem 27 is traumati			Penn Street Balt		D 21201  Dc. Location - City or Town, State
more, MD 21215-0036 Pages and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mouth Briggiente.  It is them 27 is marked other than "matural", or items 23a or 28a-fahr unit. If item 27 is marked other than "matural", or items 23a or 28a-fahr or other traumatic event, the Medical Examiner must be notified at once		Bunial 2 Cremation 3 Removal from State crematory or oth	ner place)		
Baltimore, permit. Pages 1 an Department of He Important: If ite			lame and Address of Facility ate Anatomy Boar	d 655 W.	Baltimore Street
			Itimore, MD 212	01	
Physician /Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Dis		,	Between Onset and Death
kaminer		or condition resulting in death)  Due to (or as a consequence of):			
	Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
L	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Company that initiated events resulting in death) Last Underlying Cause (Disease Cau			
executed an and al - transit	_	d			
	ledic	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box 68760 death certificate b he attending physi d for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	tal death 3 Ectopic pregna	ancy	Month Day Year
Box 687 e death certific the attending a	ysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	her (Specify)		
ires that the d signed by the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		cco use contribute to the cause of death?
S, P quires t	ted b	Cancer		1 Yes	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
Records, The law require	Completed			autopsy performe	prior to completion of cause of death?
tal Rection: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 ✓ Yes 2 No
of Vital ng Physician: After this certi	To Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other Nursin	ng Home 5 Re	esidence 6 🗸 Other: Scene
n of ding Ph  After t funeral	on: 1	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of I	njury 28c. Injury at Work?	28d. Describe how	winjury occurred
Division rate of an area of a section of a s	icati	2 Accident Investigation 28e Place of Injury - At home farm, street		28f. Location (Stre	eet and Number or Rural Route Number, City
Divis pital or At ours after d eral Direc filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Stat	e)
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death.  To the Function After this certificate has been signed by the attending physici completely filled in by the funeral director.	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occur one)  Wedical Examiner: On the basis of examination and/or investiga	rred at the time, date and place, and tion, in my opinion, death occurred a	I due to the cause(s at the time, date an	s) and manner as stated. d place, and due to the cause(s)
To I To I	Med	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		(X whene	O.C.M.E.		April 10, 2009
-		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penr	Street, Baltimore, MD 212	201	
St	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
Regist		MAY 0 8 2009 Janua & Span			
DHMH 17 Rev 1/2 OCME 2006	001	OCMF ORIGINA	L		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2009 MAY Margaret Mary Samchuck 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Center Tawson Saint Joseph Medical 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Min. Months Hours Days 1 □ M 2 🔯 F 86 26,1922 Maryland 218-18-3141 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 1 ☐ Yes 2X No Nottingham Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt. 204 21236 United States 4102 Taylor Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 TXNo If Yes, Give Year or Dates Specify 3₺ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augusta Algier William Walton 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Cholewczynski 1009 Towson Drive Abingdon, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 5/8/2009 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service Consecutive wha lu 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION UNKNOWN disease or condition resulting in death) Due to (or as a consequence of) UNKNOWN CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 1 Tyes 2 No 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred

**Physician** /Medical Examiner

item 2

permit. Pages Department of Important: If it any injury or o

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with annot of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or:

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

State Registrar

the Maryland

Physician; The law requires that the death certificate be executed burial-trar attending physician for use as the buria ned by the a o ۵. Records, page

this funeral

After

nours after death.

neral Director: A
filled in by the fu

within 24 hours a

To the Funeral C Hospital

the

completely

of Vital

Division or Attending 23b. Was decedent pregnant

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in my policion death occurred at the cause(s) and manner as stated

TOWSON, MARYLAND

and ma nner stated 29b. Signature and title of certifier

29c. License number D64509

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. OSLER DRIVE 31. Date filed (Month, Day, Year) 7601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G891, 5/8/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Linda Marie Sturmer 23:23 2009 Mau 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Days Hours 1 □ M 2 1 F August 9,1952 212-62-5049 56 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 📈 No Chester Maryland Queen Anne 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21619 104 Church Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning 9 years Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annette Lucille Schaffer Edward Charles Appel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 104 Church Street, Chester, Maryland 21619 Annette Y. Lentz sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 7, 2009 Bayview Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Somewre of Funeral Service Licensee <sup>22 Name and Address of Facility</sup> Homne Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andioc disease or condition resulting in death) Maralotic Aciders with TK TPO4. caucinum, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of

Physician /Medical Examiner

The law requires that the death certificate be executed

Hospital or Attending Physician;

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traum once.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

show

ms 23a or 28a-f shov must be notified at

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r

2 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or ite

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examine physician and s the burial-trans burial-tran 2 Be ٩

Physician/Medical Completed

SS signed by the a d be detached for ate has b certificate funeral director. this Certification: ours after death.

Ieral Director; Af within 24 hours a

To the Funeral C

completely filled Medical

State Registrar

25. Was case referred ★ medical examiner?
1 ☐ Yes 2 ▼No 27. Manner of Death

filed (Month, Day, Year)

29b. Signature and title of certifier

2[XNo

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation

6 ☐ Could not be

30. Name and address of person who completed caus 23a) (Type Print) Joseph-Herbert

28a. Date of Injury

(Month, Day

1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of

28c. Injury at Work?

to Teertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

200

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

performed? Yes 22No

28d. Describe how injury occurred

2001 Madical Desy , Annapolis Mayor

26. Place of Death (Check only one)

32. Registrar's Signature MAY 08 2009

09-03627 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William Stemmer 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 5, 2009 Medical Examiner William Alexander Stemmer 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bel Air Harford 500 Upper Chesapeake Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 09/02/1943 1 X M 2 65 Yrs 217-38-3499 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 28a-f show s 23a or 28a-f show e notified at once, more, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho wrother traumatic event, the Medical Examiner must be notified at once. Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21087 ö 2612 Rohe Drive Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 X Yes If Yes, Give Year 4 Divorced Yes 2 X No specify: Specify: White <u>\$</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maryland Department of Motor Vehicles Data Processing Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ <u>William Anton Stemmer</u> Nellie Mae Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2612 Rohe Drive - Kingsville, Catherine M. Maryland Stemmer (wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 ratment o.
Important: If injury or Removal from State Donation 5 Other Specify. 21. Signature of Funeral Service Licensee Xaas **Physician** failure. List only one cause on each line /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit ca UNPENDED AMENDED hysician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month led by the attending detached for use as Fetal death past 12 months? Pregnant at time of Other (Specify) Yes 2 No 9 Unknown death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be deta ģ Completed has been 24a. Was an autopsy performed' Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 V Natural 1 Yes 2 No Pending Director: the Certificati 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 Could not be or Town, State) determined Homicide

20c. Location - City or Town, State Moreland Memorial Gds. 05/09/2009 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part I. Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Hospital or Attending Physician: The law requires that the death certificate be executed 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Yes Other: 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa To the I within 2 the one) ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 6, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **OCME 2006** OCME

1843 hrs

Country)Maryland

21087

10d. Inside City Limits Yes 2 X No

Foreign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SKRIP CHENKO **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Hebrew Home of Greater Washington Rockville 8. Date of Birth (Month, Day, Oct. 9, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1□M 2√F Months Russia Oct. 74 220-67-5540 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director MD Gaithersburg Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 17708 Stoneridge Drive Russia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 37 No If Yes, Give 12 Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Be Completed by 3€XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor Higher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gennadly Ousyannikov Valentina (maiden not avail.) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17708 Stoneridge Dr. Gaithersburg, MD 20878 (son) Andrey Skripchenko Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State May 5, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Other (Specify) Chesapeake Crematory Beltsville, MD. 4 ☐ Donation 2009 21. Sign have of his 22. Name and Address of Facility Rapp Funeral & Cremation Service rvice Licensee M00982 933 Gist Ave. Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed2 res 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 35436 HOW TEDSEED RACK 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 08 2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H rtificate of L		Reg.	71119	14905
Ε	Physicia	an	1. Decedent's Name (First, Middle, La	st)					Day Year	3. Time of Death
	/Medic	al	Mary Liguori Somm 4a. Facility Name (If not institution, giv	erville		4h City Town or	Location of Death		009 4c. County of Deat	8:15 P. <sup>M</sup>
}	Examin	er	Long View Nursing				ester		Carr	
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birt	hplace (State or Foreign
Ü	Director		232-01-4203 Usual Residence of Decedent	ILIWI ZMF	90 Yrs.			Sep. 21,	1918 West	Virginia
	yland iow at		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar Ba-f st tified	ctor	Maryland Carroll		Manche					MXYes 2 □ No
	with th	Director	10e. Street and Number			10f. Zip Code	,	Uni	Citizen of What Co Lted Stat	esternity?
	ns 23	Funeral	3332 Main Street	12. Was Decedent B	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba			America 14. Race - Ame	
٥	or iter		1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 🌂 🛣 N  If Yes, Give  Year or Dates:	lo.	1 ☐ Yes XX No	in, mexican, Puerro  Specify:	Hican, etc.)	Black, White	
0-00-c	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ed by	312 Widowed 4 ☐ Divorced  15. Decedent's E			dent's Usual Occup		16h	Wh:	
<u>.</u>	nin 72 n "naf Medici	plete	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	(Give	kind of work done of DO NOT use retired	during most of work	ing	. 1.114 01 24011000	
7	filed within Hygiene. ther than '	Completed	12th		<u>'</u>	Cook				ool System
	ld be file ental H ked oth ic even	Be	17. Father's Name (First, Middle, Las.	")				e (First, Middle, Maid	den Surname)	
Ž	2 should and Men is marker aumatic	မ	James Himes  19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Street		rsteller ral Route Number, Ci	ty or Town, State, 2	Zip Code)
Me.	nd 2 alth a 27 is		Robert J. Sommerv	ille (Son)			urt, West	minster, N		
ore	00		20a. Method of Disposition XXBurial 2 □ Cremation 3 [	Removal from State	20b. Place of Disp cemetery, cre Green! awr	osition (Name of ematory or other place 1 Mason1c	e)   May	Date 200	. Location - City or	Town, State
	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Special Signature of Fund 1st Signature)		Cemetery		20	09  Cl	arksburg,	WV
Ď	Depar Depar Impor any Ir		am dymai	h.	Ē	Eckhardt F 3296 Charm	Tunerál C mil Drive	hapel, P. <i>A</i> , Manchest	A. Ler, Mary	land 21102
dit.	THE T		23a. Part1. Enter the disease, or consplored shock, or heart failure. List only	plications that caused one cause of	the death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	a. Art	trusc	lesotre	Vasen	bu Dise	ine	25
	/Medical Examiner		The second secon	Due to (or as	a consequence of):	in in	non F	lur Disi rélure scula		7.0
l.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):		10.	1		Jany)
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Rena	L fritis	re, Cu	round	scul_		-
8/00,	be ex			Hen	aleleza					
20	tificate g phys	ledical		d	_0_					
X Q Q	v requires that the death certific been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopicpregnancy	/		23d. Date of de Month	livery Day Year
5	he death the atten shed for u	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)				,
7	requires that the een signed by the rould be detache	by Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
cords	v requires been sig should be							1 Tes	2 No 3 ₽	robably 4 Unknown
jecc	law range law range be	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Iair	sician: The law certificate has t irector, page 2 s		OF Management and the last					performed 1  Yes 2 ▲		3 2 □ No
>	ding Physician:  After this certific funeral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Outpatie	ent 3 DOA Oth		th <i>(Check only one)</i> ome 5 ☐ Residenc	e 6 ∐Other (Spe	ecify)
n or	ding Phys 1. After this funeral di	T :uc	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da)		Wor	y at k?	28d. Describe how		
UNISION	ten eath tor: the	icatio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	De Place of inju	ury - At home, farm, s		Yes 2 □ No	28f Location (Street	at and Number or F	ural Route Number,
2	al or Atten after deatl Director: d in by the	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	noot, taolory, omoo		City or Town, S		arai i rocco i carriso.
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examination and/or	nvestigation, in my	opinion, death occu	rred at the time, date	and place, and du	e to the cause(s)
/	To the within 2 To the comple	Me	29b. Signature and title of certifier	\ / /		29c. Licens	se number	29d.	Date signed (Mon	th, Day, Year)
			John W.	middle	tomo	DZ	-5443	3	16/20	09
			30 Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)	4.0-4	mani	another.	th, Day, Year)  99  MD 21102
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1019	·/EEI		157/61	-1D -110 E
	Registi		MAY 08	2009 Dens	un B. x	parker				

			1 - For State Registrar	State of Ma	aryland / Depa — <i>Cel</i>	artment of H rtificate of I		nd Mental Hy	giene Reg. No	200	1490
	Physici	an	1. Decedent's Name (First, Middle, La	ist)				2. Date of De Month		yYear	3. Time of Death
	/Medic		Glenn Morrell					April			2:03 PM M
	Examir	er	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or		Death	4c.	. County of Deat	
a Band			Dove House  5. Social Security Number 6.	7.45	/la um lant hirthday)	Westmin		Hrs Doto of Die	th	Carrol	
	Funeral Director			Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last birthday) 88 Yrs.	Months Days		Min. (Month, Da July 1	8, Year)	920 Pen	hplace <i>(Stat</i> e o <i>r Foreign</i> untry) nsy <b>lvania</b>
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	ŗo	MD Carroll		Mt. A						1 □Yes 2√□No
	n with the riga or 28a-	Funeral Director	10e. Street and Number 6190 Challedon C	ircle		10f. Zip Code	21771		10g. Cit	tizen of What Co	untry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Medical Examinat must be undiffied at		11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 1 Yes 2 □ N If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cuba 1 □Yes 2🌠 No	ispanic Origin an, Mexican, P Specify:	n? (Specify Yes or No Puerto Rican, etc.)	)-	14. Race - Ame Black, White Specify: wh	e, etc.
21215-0036	n 72 hour "natural	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of	f working	16b. K	ind of Business/	
212	withii iene. • <b>than</b>	l mo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	1 worker	'/			stee1	
p	i Hyg other	Be C	17. Father's Name (First, Middle, Las	1)			18. Mother's	Name (First, Middle	, Maiden		
<u>la</u>	Ald be Alenta rked tic ev	To B	Oscar Adolph Swa	artz			FLor	rence Fran	cis	Pry	
Maryland	d 2 should be filed within : Ith and Menta! Hygiene. 27 Is marked other than ": traumatic event, the Mes	100	19a. Informant's Name/Relationship Glenn M. Swartz					or Rural Route Numb			Zip Code) 771
altimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 I any Injury or other tra		20a. Method of Disposition  1  Burial 2  Cremation 3  4 Donation 5 Other (Speci	Removal from State	20b. Place of Dispo cemetery, crea			Date		ocation - City or	Town, State
Balti	permit, Pages 'Department of Important: If ite any Injury or of Ores.		21. Signature of Suneral Service Lice ROTA of S	Wade, three	ector	2. Name and Address State Anat Baltimore	tomy Bo	pard 655 W	I. Ba	altimore	Street
	Physician /Medical Examiner		23a. Part 1 Enter the disease, or on shock, or heart failure. List only Immediate C e (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or b.	a consequence of):	er the mode of dyin	ng, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):						4/2z(ca+) (12)
O. Box (	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у			23d. Date of de Month	livery Day Year
rds, P.	quires that in signed build be deta	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did			o the cause of death?
		Completed						24a. Was auto perfe 1 □ Yes		prior to death?	utopsy findings available completion of cause of
/ita	Physician: The r this certificate rai director, pagi	Be (	25. Was case referred to medical examiner?				26. Place of	Death (Check only			
× ×	Physic this c	D D	1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie		4 🗀 Nursi	ing Home 5 ☐ Res	idence	6 Other (Spe	city) Dove Her
	ing Affe une	ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day	ry 28b. Time o Injury	Worl	yat k? Yes 2∐No	28d. Describe	how inju	ry occurred	
Division	⊒ afte	Certification:	3 Suicide 6 Could not be determined		rry - At home, farm, str c. (Specify)	eet, factory, office		28f. Location ( City or To	Street a	nd Number or R e)	ural Route Number,
	Funda tely tely	Medical (		hysician: To the best of miner: On the basis of and manner sta	examination and/or in						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	P. mo	0 dn	29c. Licens	0 1 6	67	,	ate signed (Mont	h, Day, Year)
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print)	1013	0 21	15	7 6320	
	Sta	10	31. Date filed (Month, Day, Year)	He St 32. Registra	Wost ar's Signature	m. 1560	yn,	1) 211	1) 7		

State Registrar

		Please	e Type or Pri							Legible	<u>.</u>	
		For State	State of Ma	aryland		artment of <i>tificate of</i>	Health and I		giene Reg. No.	200	0 11.	007
		Registrar  1. Decedent's Name (First, Middle, Las	it)				Dodin	2. Date of De	ath	200	3. Time	of Death
Physic /Medi		James			Sti	ckles		April	3 p	2000	1 4:4	5 AM
Exami		4a. Facility Name (If not institution, give		•			or Location of Death	1	4c.	County of De	eath	
4.3		The Johns Hopkins H  5. Social Security Number 6. S		e (In yrs. last	birthday)	Baltimor		8. Date of Bir	th	9. F	Birthplace (State	or Foreign
Funeral Director			<b>X</b> M 2□F	50	Yrs.	Months Days	Hours Min.	Dec 3	1, 19	58 Wa	Country) shingtor	n DC
pui »		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	cation					10d. Inside	City Limits
Maryla -f sho ed at	힏	MD Carroll			kesvi						1 □ Y∈	es 2 No
h the l or 28a notifi	irec	10e. Street and Number			110011	10f. Zip-Code	-		10g. Citiz	zen of What (	Country?	
ath wit 23a c	ra	963 C Lorimel Roa				_	sville			USA		
and 21215-6036  be filed within 72 hours after death with the Maryland hal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 🕅 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🔀	Ever in U.S.	13. V	Was Decedent of f Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Ar Black, Wi	merican Indian, hite, etc.	
Z15-UU36 thin 72 hours aft e. an "natural", or Medical Examir	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	1 ☐ Yes 2X No	Specify:			Specify: W	<i>i</i> hite	
5-0 72 hor natura lical E	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		(Give	dent's Usual Occ kind of work don	e during most of wo	rking	16b. Ki	nd of Busine	ess/Industry	•
vithin "han "	lg m	Elementary/Secondary (0-12)	College (1-4 or 5	5+)		00 NOT use retir chanic	ed)			autom	otive	
filed / Hygie other i	ပိ	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	e, Maiden			
aryland should be t and Mental H s marked of umatic ever	To Be	Lionel Edward S	tickles Jr					Elizabe				
<b>Baltimore, Maryland</b> permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.		19a. Informant's Name/Relationship ( Wanda Stickles/s					et and Number or R 1 Road Sy					
e, E		20a. Method of Disposition				sition (Name of		Date			or Town, State	
<b>Baltimore</b> , permit. Pages 1 ar Department of Hee Important: If item any injury or othe once.		1 Burial 2 Cremation 3 4 X Donation 5 X Other (Specif	Removal from State	cen		natory or other p	lace)					- 1
altir mit. F partme sortan / Injur		21. Signature of Funeral Service Licen Ronal d			\$ S.t	2. Name and Add	ress of Facility	4 655 W	Ra1	timore	a Street	
		/Xmn////			1		•			CIMOIC	Approxim	
100		23a. Part Enter the is as , or c^m shock, r heart f ilure. List only Immediate Ca (Final	one cause on each lin	the death.	Do not ent	er the mode of d	ying, such as cardia	ic or respiratory	arrest,		Interval B Onset an	etween
Physician /Medical		disease or condition resulting in death)	a. Due to (or as	5 5 ( a conseque	nce of):	oma						
Examiner	١.	Composticible list conditions	6 Cent	ral	AR	rea					-1,	
p #	njner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	Doe to (or se	а солвадие	nes of, a							
9, e executed an and urial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a conseque	nce of):							
60, e be ex sician e burie	edical		_ d									
<b>Box 6876</b> (leath certificate be attending physicid for use as the but	Med	IF FEMALE:										
death cer e attendir ed for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 🗌 Fetal d	eath 3	☐ Ectopic pregna☐ Other (specify)			1	23d. Date of Month	delivery Day	Year
the de y the a ached	hysic	1  Yes 2 No 9 Unknown	9 Unknown	it time of dea	ui 3 L							
cords, P.O. Bc requires that the death been signed by the atte should be detached for	by P	Part II. Other significant conditions	contributing to death h	but not result	ing in the u	underlying cause	given in Part I.	23e. Did	tobacco u		te to the cause of	
ould b		1				_	-	100	Yes 2			Unknown
0 8 0 N	Completed							24a. Was auto perf		24b. Were prior deat	e autopsy finding r to completion of th?	of cause of
		25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only	2 No	1 🗆 '	Yes 2 No	
of Vital I Physician: The this certificate tral director, pag	To Be	examiner?	Hospital:	ent 2 EF	R/Outpatier	nt 3 🗆 DOA	Other: 4 \(\sum \) Nursing H			6 ☐ Other (\$	Specify)	
<b>○</b> # # # #	Ë	27. Manner of Death	28a. Date of Inju	ury 2	8b. Time o	of 28c. In	jury at /ork?	28d. Describe			_	
Division or Attending after death. Director: After lin by the fune	catic	2 Accident investigatio		iun. At hom	a farm etr		☐ Yes 2 ☐ No	28f Location	(Street ar	nd Number c	or Rural Route N	lumber.
Divisic	Certification:	4 ☐ Homicide determined		tc. (Specify)	e, iaiii, sii	eet, lactory, offic	6		wn, State		n marca mosto m	
Div To the Hospital or Ai within 24 hours after of To the Funeral Direc	edical C	(check only 2 Medical Exa	hysician: To the best miner: On the basis of	of examinatio	edge, deatl	h occurred at the	e time, date and place by opinion, death occ	e, and due to the	e cause(s e, date an	) and manne d place, and	er as stated. If due to the caus	se(s)
To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner st	tated.		29c. Lice	nse number		29d. Da	te signed (M	fonth, Day, Year)	
<b>7</b> w <b>6</b>		Halen	1 lea	6	MO	RE	5-66	d	Aor	:130	20	69
		30. Name and address of person who	completed cause of	death (Item :	23a) (Type,							
		21 Data filed (Marth Day Your)	8,00 645	rar's Signatur			600	North W	olfe S	t, Baltii	more, MD	, 21287
S Regis	tate trar	31. Date filed (Month, Day, Year)		a s digitatul		Red						

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Louis Sharp 26, 200 4a. Facility Name (If not institution, give street and number 4b. Gity, Town, or Location of Death 4c. County of Death lland more GIENERAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Months Min. Davs 1 X M 2 □ F Hours 219-38-3806 66 Aug 7, 1942 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits MDty⊡Yes 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2327 N. Charles Street 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Bace - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 X No If Yes, Give Year or Dates 1 ☐Yes 2X No Specify. Specify: black 3 ☐ Widowed 4 💢 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew Olney Sharp Lula Mae Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vandonia Jackson/sister 1049 Stone Place Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(\pecify) in state 21. Signature of Euneral September 21. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part LEnter the disgase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ( r as a consequence of) Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

ral", or items 23a or 28a-f shor Examiner must be rictified at

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter may njury or other traumatic event, If wedlett Examir or and.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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with the Maryland

Examiner attending physician and for use as the burial-tran Physician/Medical the a signed by t ò certificate has been s rector, page 2 should Completed director, Be After this Certification: To funeral within 24 hours after death To the Funeral Director: the 1

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician;

Hospital

the

death.

in by t

filled

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

25. Was case referred to medical examiner?

2 12/No

1 ☐ Yes

27. Manner of Death

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a, Certifier

24b. Were autopsy findings available prior to completion of cause of death?

autopsy performed 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

08

5 Pending investigation

6 ☐ Could not be

determined

Hospital

28a. Date of Injury (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hilus 31. Date filed (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BCQVes Day 2009 Year Schillina Month **Physician** 8120 A M 12) /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MANI Lutherm Wes minst V11/392 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth June 4, 1916 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In rs. last birthday **Funeral** 1**∑**M 2□F Months Mary I and 92 Director 215-07-4610 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Carroll WEstminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 St. Mark Way 21158 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 supervisor bethlehem steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Charles Reuben Schilling Marie Camelia Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Schilling/spouse 200 St. Mark Way Westminister, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signatu e Funeral Service · Wade 22. Name and Address of Facility Mixector. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Inter the disease or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** kws /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate 2. No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ို this funeral 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation spital or Attendii lours after death. neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of p word who complete cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed Month, Day,

2.45

32 Registrar's Signature

Stoney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 6 44PM MAY 2004 Sapeta Joseph F. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE
If Under 1 Year | If Under 24 Hrs. SMINT AGNES HOSP, TAL 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) Oct 26,1936 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 M M 2 □ F Oct 216-32-3356 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 ☐ Yes 2 No Dunda1k Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21222 537 Larkfield Road 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? ty∏Yes 2 ∏No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) & fork lift Beth Steel 1274 worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Kropp Jospeh Sapeta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5265 Lightfoot Path Columbia, Md. 21044 Mary Helfrich (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 5-8-2009 Balimore, Maryland 4 ☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility Raczorowski Funeral Rome, PA 21, Signature of Aneral Service icensee 1201 Dundalk Avenue Baltimore, Md.21222 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DAYS a UPPER GASTRO INTESTINAL disease or condition resulting in death) Due to (or as a consequence of): WEEKS GASTRO-ESOPHAGE AL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): WREKS DUODENAL ULCED resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) a I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPER TENSION

executed Box 68760, requires that the death certificate be o W ₫. 705 Division of Vital Records,

E PETA

physician and s the burial-trans been signed by the should be detached

Physician/Medical Examiner

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Completed

**Physician** 

Examiner

/Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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Be Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20... any injury or other traumatic event. The second pages.

s certificate has b or Attending Physician: within 24 hours after death

To the Funeral Director;
completely filled in by the t

Di/	ABET	ES MELL	ITUS			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No	
25. Was case referred to	medical				26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 Anpatient 2	ER/Outpatient	3 🗌 DOA	Other: 4 \( \text{Nursing I}	Home 5 ☐ Residence 6	Other (Specify)	
27. Manner of Death	☐ Pending investigation	(Month, Day, Year)	28b. Time of Injury	28c.	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred	
	Could not be determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)		

Medical Certification: To Be 29a. Certifier (Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P21617

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVENUE BALTIMORE, MD 21229 CATON OFOSU, MD 900

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gerarde Leon Thom	npson, Sr. S	tate of Marylar		rtment of		d Mental		20	009 1491
Physician/	Registrar  1. Decedent's Name (First, Midd	ile,Last)		timodio oi			2. Date of Dea		3. Time of Death
Medical Examiner	GERARDE LEO	N THOMPSON					Month May 4, 20		0855 hrs
•	4a. Facility Name (if not institution  Compass Road and I		ber)		4b. City, Town, or Middle Rive		ath	4c. County of E Baltimore	
Funeral	5. Social Security Number		. Age (In yrs. Ia	ast birthday)	If Under 1 Yea		Hrs. 8. Date of Bir		Birthplace (State or Foreign
Director	213-84-0710	1XM 2F		42 Yrs	Months Day	s Hours N	Min. 08/09	/1966	Country) MARYLAND
<b>&gt;</b>	Usual Residence of Decedent	<u>'</u>	I40+ Oite	Table as Least					10d. Inside City Limits
ow any	10a. State 10b. County Indiana	TETMODE		Town or Locat		MIMODE.			1 X Yes 2 X No
nyland sa-f sh nt once	MARYLAND BA	BTIMORE	ВТОС	mingto	10f. Zip Code	IIMONE	<u> </u>	l0g. Citizen of What	
the Marylanc a or 28a-f sh <u>tified at onc</u>	1007 W. Pinehu	rst Dr.			47	403 <del>220 -</del>		U.S.A.	
death with ritems 23 nust be not	11. Marital Status	12. Was Deced			is Decedent of His es, specify Cubar		( Specify Yes or No	o- 14. Race - A White, e	American Indian, Black,
or ite	1 Never Married 2 X	1 Yes	2 XX No				sito rican, etc.)		
rs afte	45 0 1 51 62	vorced If Yes, Give Year or Dates:	completed)		Yes 2 X No		of work done	Specify: 16b. Kind of Busin	BLACK ness/Industry
-0036 siene. Beten "natu het fan "natu het fan "natu het fan "natu het fan "natu ompleted"	Elementary/Secondary (0-12				ost of working life				,
5-0036 iled within 7 Hygiene. I other than th Medica	12th grade			PR	OF. TRUC			MJM DI	ST.
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2121 ould be fill Mental I marked c event,	JAMES THOMPS  19a. Informant's Name/Relation			19b. Mailin	g Address _(Ştre		LLE THOM or Rural Route Nu	mber, City or Town,	State, Zip Code)
MD d 2 sho lth and lth and n 27 is aumati	Catherine B. T	hompson/Wi	fe	1007	W. Pin	ehurst st Dr.,	Bloomin	gton, Ind	liana 47403
rre, s 1 and freal of Heal	20a. Method of Disposition  1 Burial 2 XXCrematic	n 3 Removal from		Place of Dispos crematory or of	sition (Name of ce her place)	metery,	Date	20c. Location - C	ity or Town, State
Baltimore, permit. Pages I at Department of Hee Important: If ite	4 Donation 5 Other 8	Specify:			EMATORY		5/13/09		ORE, MARYLAND
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	21. Signature of uneral Service	Brown		1	206 W NC	RTH AVE	E. BALTIM	ORE, MD.,	HOME P.A. 21217
Physician 'Medical	23a. Par(I. Enter the disease, of failure. List only one caus		used the death	. Do not enter t	he mode of dying	, such as cardia	ac or respiratory ar	rest, shock, or heart	Between Onset and
kaminer	Immediate Cause (Final diseas or condition resulting in death)	e a. Multiple Inju		·A·					Death
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Box 6876C he death certificate the attending phys hed for use as the b Physician/Me	23b. Was decedent pregnant in past 12 months?	I Live bii	th nt at time of de		etal death 3	Ectopic pre	egnancy	Month	Day Year
J. Box the death of by the atter toched for us	1 Yes 2 No 9 U			5 _ 0	ther (Specify)	N 100 - 100		9	
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of Vital Records, ig Physician: The law requirement is certificate has been signered director, page 2 should be not To Be Completed	k		_				auto	ppsy pri	or to completion of cause of ath?
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Vital Vital hysician this cert d directo	examiner?	Hospital	patient 2	ER/Outpatien		Othor	ursing Home 5	Residence 6	Other: Scene
n of ding Ph. After ti funeral	27. Manner of Death	28a. Date of May 4, 20	of Injury Day, Year)	28b. Time of		ury at Work?	Driver auto	how injury occurred	
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Division oppinal or Attending ours after death. Irran Director: Aft filled in by the function: Certification:	det det	uld not be	of Injury - At h		eet, factory, office	building, etc.	or Town.	State)	or Rural Route Number, City oulevard, Middle River , MD
\$ 2 E E O	4 Homicide	Physician: To the best			irred at the time, o	date and place,			
To the Hos within 24 h completely completely		aminer: On the basis of and manner sta	f examination a						
F * F * S	29b. Signature and title of certification		~			se number			d (Month, Day, Year)
	Musi	anell M	\partial \text{\partial \text{		0.0	.M.E.		May 4, 2009	,
OCME	30. Name/and address of personal Melissa Brassell, MD			·	Penn Street,	Baltimore, I	MD 21201		
State	7 1 1 1		gistrar's Signat	ur <b>a</b>					
Registra	MATUC	ZUUY Ken	ma 1	J. 190	Mal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 May 5, **Physician** 1:50 AM Dorothy Brown Taylor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, )
Nov. 10, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Months Days Hours Min 1 □ M 202 F Virginia 1924 84 Director 216-20-8685 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 7 is marked other than "natural"; or items 23a or 28a-f show traumatic event, the Modical Examination of the profiled Modical Examination. 1 ☐ Yes 2 No Director Whiteford Harford Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 4118 McNabb Road 21160 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2√∑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🔀 No Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 9 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alma Elizabeth Herron Clarence Daniel Baber ၉ permit. Pages 1 and 2 st.
Department of Health and
Important: If Item 27 is ma
any injury or other trauman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4118 McNabb Road, Whiteford, Maryland, 21160 Alfred P. Taylor / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/9/2009 Joppa, Maryland Christian Cemetery 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signatur of Funeral Service tell 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final day Physician 2 ongeitur disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner OCardia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner s been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 Other (specify) P.O. 9 I Inknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AY/0R, JONSANY Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier

State Registrar 31. Date filed (Month, Day, Year) MAY 08 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Veal Physician MM 1573 ELBERT TAYLOR 06 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORP AR UPPER CHESAPEAKE MEDILAL CEMBR If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days Hours Months Min 242-70-3787 1 M 2 F North Carolina 01/05/1943 66 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐No Director Maryland | Harford Forest Hill 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 14. Race - American Indian, 21050 126 Paden Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ➡No Specify: Specify څ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 P<u>ress Operato</u>r Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ဂ Marjorie (nmn) Bell <u>Benjamin Joseph Taylor</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 126 Paden Court, Forest Hill, MD 21050

a of Disposition (Name of Date 20c. Location - City or Town, State Richard Taylor / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State Hilltop Service Corp. 5-11-09 4 □ Donation 5 □ Other (Specify) Towson, Maryland 4 LIDonauc..
21. Signature of Funeral Service McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21050 23a. Part1. Enter the disease, or complications that caused the death shock, or hear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) AURY HIMIA CALDIAL Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 2 □ No 4 ☐Unknown 1 □ Yes DISFASE CORONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ALCIDENT. CECEBILO MASCULAN autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 √Yes 2 No 2 ER/Outpatient 3□ DOA ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mannes of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Physician /Medical **Examiner** physician and the burial-tran  $| \alpha y |_{OC} = CIDeCt$ Division or Vital Records, P.O. Box 68760, nding phuse as t certificate funeral director, thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu

**Funeral** 

Director

00058856 Maryland 21215-0036

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title MD. 67360

BEL

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State Registrar

DHMH 17 Rev 1/2001

CHESAPEAKE

UPPER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABRAHAM

UNICHMEL

MAY 08 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8:50 P M **Edna Wessel Thompson** Apr 25, 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Williamsport Washington 11003 Bragg Court If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Months 1 □ M 2 X F MD 218-12-8844 Aug 5, 1923 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2 No Williamsport MD Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 11003 Bragg Court. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Family Owned Store Family Business** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **Edward August Wessel** Margaret Henriette Zeltman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11003 Bragg Ct. Williamsport, MD 21795 Willis T. Thompson Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Lutheran Cemetery Apr 29, 2009 Fulton, MD nature of Furniral Savin 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerosis Kars Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

The law requires that the death certificate be executed and burial-trar P.O. Box 68760, ed by the attending physician detached for use as the buria cate has been signed by page 2 should be detacl Division of Vital Records, Hospital or Attending Physician:

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Physician/Medical

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Completed

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?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examination at

Department of Health ar Important: If item 27 is any injury or other trau

**Physician** /Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or:

Baltimore, Maryland 21215-0036

the Maryland

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State

Certification: To Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D45813 NO A:RIL 27, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EGNER

MEDICAL CAMPUS RD 11110

W 31. Date filed (Month, Day, Year) MAY 08

Registrar's Signature

Registrar

STE 132 HAGERETOWN MO 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 40M **Physician** William ARI. 200 /Medical County of Death 4b. City, Town, or Location of Death 4c. 4a. Facility Name (If not institution, give street and number) Examiner DALLS CONN HOSPITAL CONTO NONTHINES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1**X** M 2□ F 72 213-34-6061 Feb 4, 1937 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show the Medical Expression count be notified at 1 □ Yes 2√√ No Director MD Middle River Baltimore the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō filed within 72 hours after death with 705 Compass Road #325 21220 USA items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 21 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2X No white Specify: þ 3 ₩idowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. It — M. College (1-4or 5+) Elementary/Secondary (0-12) 12 education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris May Buckley Bernard Barksdale Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Amanda Thompson/daughter 104 Riverside Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Ştate 4 Donation 5 Dother (Specify) 21. Signatur, of Euneral Service Licensee State Anatomy Board 655 W. Baltimore Street Wirector 21201 Baltimore, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** E disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEUMONI. Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a conse juence of Examine Physician: The law requires that the death certificate be executed and -trai resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown been signed by the should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 1 ☐ Yes 2 ☑ Ne 2 2 N director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Lopatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mann of Death funeral To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORTHW CONTENAL ORIXXDO ne 32. Registrar's Signatu 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

08 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ 1 - For State Registrar Certificate of Death Reg. No. ame (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 75 lx /Medical (If not institution, give street and number) 4c. County of Death Town, or Location of Death **Examiner** (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If we Medical Examinat must be retified at Director 1 es 2 No MD10e. Street and Number 10g. Citizen of What Country? 5, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 📉o Specify ≥ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life; DO NOT use retired) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of uneral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATIC WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-tran Box 68760,2 Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check onl one Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours arter community to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific MAY 6,2009 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NCHALLES ST. SUITE 209 BALTIMURE, MD 21204 MO 6565 32 Registrar's Signat 31. Date filed (Month, Day, Year)

State

Registrar

082009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 11:41 PM 2009 MARY WHEATLEY FRANCES YAM 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR N/A HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-31-1959 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1 □ M 2 X F Months Days Hours Min. 218-76-2759 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Exprainer must be notified at Maryland Baltimore Highlands Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2738 Virginia Ave. 21227 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wheatley Theresa Stafford ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Wheatley, Daughter 2738 Virginia Ave. Baltimore, MD. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. Atlantic Crematory 05-06-09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arbutus, M Approxima e Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS MRSA Sequentially list conditions, in a line cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-trans P.O. Box 68760 Due to (or as a consequence of): attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably .4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 ☑No 2 🗆 No Attending Physician: funeral director, Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 VNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation al or Attendi s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES DOD

State Registrar

JEET GANDHI 31. Date filed (Month, Day, Year)

3001 SOUTH HANOVER STREET, BALTIMORE,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY

2009

MD-21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 1- Registrar Amend Item 1 per dr., g891,05/08/09dhb Reg. No. Reg. No. Waggener 1. Decedent's Name (First, Middle, Last) Darlene 2. Date of Death 3. Time of Death April 24, 2009 2009 Day **Physician** Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Pasadena 7821 East Shore Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye Oct. 30, 5. Social Security Number 7. Age (In yrs. last birthday) . 1949 **Funeral** Days 1 □ M 2 💢 F Yrs. Maryland 59 **Director** <u> 214-52-8741</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it as Evolical Exyrain at the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director Anne Arundel Pasadena 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 21122 by Funeral 7821 East SHore Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology 10 Hairdresser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Waters Chester Roper ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7821 East Shore Road, Pasadena, MD 21122 Tracey Bohle - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Rurial 2 ☐ Oremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Cedar Hill Cemetery 5-1-2009 Brooklyn, MD Si nutre of Juner Service L 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardine **Physician** /Medical Due to (or as a consequence of): Examiner thepoxenia Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Chronic obstructive pulmonary disease The law requires that the death certificate be executed attending physician and for use as the burial-tran Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ■No Month Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No Division of Vital 1 ∐Yes 2 ⋈ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-27-09 D0025134 (and oresign 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 3169 BRAVERSON
31. Date filed (Month, Day, Year)

32 Registrar's Signature

33 Registrar's Signature

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			, rui	tment of Health and Mental Hygie	ener UUD 14313
			1 - State Registrar Certification	ificate of Death Reg.	. No.
	Physici /Medio		1. Decadent's Name (First, Middle, Last)  Dertho M. Wegener	2. Date of Death Month	Day Year 416 PM
4	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death  Do 1 + 1 - 1 - 1
	Funeral Director			If Under 1 Year   If Under 24 Hrs.   8. Date of Birth Months   Days   Hours   Min.   (Month, Day, Year)	9. Birthplace (State or Foreign Country)  9. Birthplace (State or Foreign Country)
	ס		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	0 7	10d. Inside City Limits
	the Mar	rector	MD DOITMORE COCKE	USONE 10g	1 ☐ Yes 2 1 1 No  Citizen of What Country?
	leath with ns 23e o	Funeral Director	300 International Circle  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Armed Forces?	as Decedent of Hispanic Origin? (Specify Yes or No- res, specify Cuban, Mexican, Puerto Rican, etc.)	U.S.H -
9500	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show shy injury or other treumatic event, I'm Medical Examinar must be notified at ance.	by Fun	1 Never Married 2 Married 1 Yes 2 17No	/es, specify Cuban, Mexican, Puerto Rican, etc.) ☑ Yes 2.th No Specify:	Black, White, etc. Specify: White
<u>ک</u>	72 hou	eted	(Specify only highest grade completed) (Give kii	nd of work done during most of working	b. Kind of Business/Industry
7	l within jiene. r than '	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)	NOT use retired)	Silversnith
yland,	d be filed ental Hyg ked othe c event,	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma	iden Sumame)
Mary	d 2 shoul th and Me 7 is mark treumati	ř	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Route Number, C	City or Town, State, Zip Code)
a)	ges 1 an t of Heal if item 2 or other		20a. Methed of Disposition  1  Burial 2 Cremation 3 Removal from State	ion (Name of Date 20 tory or other place)	c. Location -/City or Town, State
Baitimor	ermit. Pa spartmen sportant: ty injury		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  22. 1	Name and Address of Facility no Funcio	I chapel - Monkton
ם	70E 9 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	124 YOK Rd. MONKTO	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a	tut	Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):		
K	be executed siclan and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
3/60,	ate be ex nysician he burial	ā	d		
200	entifica ling ph e as t	Med	IF FEMALE:		
.c. Box	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medic		ctopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
7	that the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I. 23e. Did tobar	cco use contribute to the cause of death?
ecords,	law requires that the as been signed by th 2 should be detache		Cerebolasulen Dassese, H+W,	GERD, DM 10 Yes	2 No 3 Probably 4 Unknown
r	The law ate has be page 2 st	Completed	CAD, MmE	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 (V) No
Vital	cien: entific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
0	Physi r this c aral dir	: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA Other: 42 Nursing Home 5 Residence 28c. Injury at Work? 28d. Describe how	
lon	arth. r: Afte	atlor	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
DIVISION	el or Atte s after de il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	at, factory, office 28f. Location (Stre- City or Town, S	et and Number or Rural Route Number, State)
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death of the best of my knowledge, de	occurred at the time, date and place, and due to the caussigation, in my opinion, death occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number 29d	. Date signed (Month, Day, Year)
'	)		R.T. fullett, m., 30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	int) Daiy6y	5-7-09
	<i>\psi\</i>		Robert LiBerts, MS. 350 & Boul ST B	cello, ma 21224	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
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Henry Jerome Ware, Si	•	
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09-03513	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legil
Henry Jerome Ware, Sr.	State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of I	Death	Reg	. No. 200	9 1496
Physician	Decedent's Name (First, Middle,Last)			Date of Death     Month	Day Year	3. Time of Death
ledical Examine	HEIGHT SEROTE WAT			May 1, 200	9 ′	1150 hrs
	4a. Facility Name (if not institution, give street and number) 2314 Brooks Drive, Apartment 302		o. City, Town, or Location of E Suitland	Death	4c. County of Death Prince George	S
Funeral Director		yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	Min	(MM/DD/YYYY) 9. Birth Foreign	place (State or
Director	242-44-4123   1XM 2F   74  Usual Residence of Decedent	Yrs.		JUNE 13	3 1934   <sup>දෙ</sup> ජ	NORTH AROLINA
any		. City, Town or Location	n	-		10d. Inside City Limits
Aaryland 28a-f show any Latone	MD PRINCE GEORGE'S	SUITLAN	ID			1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at one.			10f. Zip Code 20746	109	g. Citizen of What Count USA	ry?
s, MD 21215-0036  and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers tem 27 is marked other than "natural", or items 23a or 28a-fish traumatic event, the Medical Examiner must be notified at one To Be Completed by Filmeral Director		rforce fres	Decedent of Hispanic Origin's, specify Cuban, Mexican, P		14. Race - Americ White, etc.	
ural",	3 Widowed 4 X Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)		res 2 X No specify: s Usual Occupation (Give kin	d of work done	Specify: BL/	ACK dustry
11215-0036 Id be filed within 72 hours Admila Hygiene. narked other than "nature event, the Medical Exam	Elementary/Secondary (0-12) College (1-4 or 5+)	during mos	st of working life. DO NOT us  CATION SPECIA	e retired)	PRIVATE	
5-0036 Iled within 72 Hygiene. I other than the Medical	17. Father's Name (First, Middle, Last)		18.Mother's I	Name (First, Middle, M	aiden Surname)	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 77 popurate I permit I have a few and 14 yeare. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Re Commite	LURAY JEFFERSON		CORA	LEE WARE		
hould I Mer is man artic ev	1		Address (Street and Number			· '
md 2 sho salth and em 27 is	DEBORAH WARE/DAUGHTER  20a. Method of Disposition		on (Name of cemetery,	Date Date	VALDORF, MAR 20c. Location - City or	
Baltimore, permit. Pages I an Department of He Important: If ite	1 X Burial 2 Cremation 3 Removal from State	crematory or othe	r place)		·	
ltim iit. Pa urtmen ortant	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee		NS CEMETERY 5		CHELTENHAM	
Balti permit. Departm Imports			74 LANDOVER F			
Physician	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.					Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease a. Atheroscle		lovascular di	sease		Death
/	Fibrosis of		plicated by 1	hypertherm:	ia	
led msit						7
ecuted and transit						
exe dan a lal -	X UNPENDED X AMENDED I 1ir	ne a-b, 27, <b>g891 5-19</b> .	28a-f,perME,	g891 5/11	/09 TT	
8760 ificate ig phys s the b	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of	f pregnancy	I death 3 Ectopic p	regnancy	23d. Date of delivery Month D	ay Year
Box 68760, edeath certificate be attending physical for use as the burnsical analysis.	past 12 months?  4 Pregnant at time	of death	er (Specify)			,
O. BC nat the deed by the a ctached for	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause given in Part	I. 23e. Did tob	pacco use contribute to t	he cause of death?
by P.C. signed I d be deta				1Yes	2 V No 3 Prob	
Division of Vital Records, P.O. Box 68 optial or Attending Physician: The law requires that the death certimeral Director: After this certificate has been signed by the attending yfilled in by the funeral director, page 2 should be detached for use as Certification: To Be Completed by Physician				24a. Was an autops perform	y prior to co ned? death?	opsy findings available ompletion of cause of
tal Rection: The certificate ector, page			26.Place of Death (C			
Vital Institute Institute Vital	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient	3 DOA Other	Nursing Home 5 F	Residence 6 🗸 Other:	Scene
n of ading Plan.  : After the funeral control.	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  Tel: 5 / 1 / 00	28b. Time of Inj	- X- X	0	ow injury occurred exposed to	very
Division tal or Attendir rs after death. at Director: A led in by the fu	2 X Accident Investigation 28e. Place of Injury		o am factory, office building, etc.	warm en	vironment treet and Number or Rur ate)2314 Broo	al Route Number, City
Division or strending hours after death.  neral Director: After filled in by the fune.  Certification:	3 Suicide 6 Could not be determined (Specify)	house		Apt 302	Suitland,	ks Dr MD
Division  To the Hospital or Attendit within 24 hours after death.  To the Funeral Director: A  completely filled in by the fi Medical Certification	29a. Certifier 1 Certifying Physician: To the best of my knot one)  2 Medical Examiner: On the basis of examina and manner stated.					
F F F S D	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)
	Marganie The Vivele		O.C.M.E.		May 2, 2009	
	30. Name and address of person who completed cause of death Margarita Korell MD. Assistant Medical Exa		nn Street, Baltimore, I	MD 21201		
State	01-01-01-01-01-01-01-01-01-01-01-01-01-0		20.0			

09-03078	
Danyell Williams	

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State of Manyland / Department of Health and Mental Hygiene

inyeli Willia	ms		- For State	of Maryland / I	•	tificate of Dea		ı wenta		ea. No.	200	9 1496
. Physi	icia		Registrar 1. Decedent's Name (First, Middle,Last)	)					2. Date of Dea	ith	Year	3. Time of Death
edical Exa		er		nyell	Wi	lliams			Month April 17,		County of Death	1607 hrs
			4a. Facility Name (if not institution, give Bon Secours Hospital	street and number)		1	timore	Location of D	Jeath	40. 0	County of Death	
Funer	al	-	Social Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Second Security Number 6. Second Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Second Security Number 8. Second Second Second Security Number 8. Second Seco	x 7. Age	(In yrs. la	st birthday) If U	nder 1 Year	r If Under 2	24Hrs. 8. Date of B	rth(MM/DI	D/YYYY) 9. Bir	thplace (State or
Direct				M 2 XF	3	36 Yrs. Mo	nths Days	Hours	Min. 9-2.	L-19	73 Foreig	untry) M.D.
		-	Usual Residence of Decedent									10d. Inside City Limits
w any			10a. State 10b. County	1	•	Town or Location						1XX Yes 2 No
Maryland 28a-f show	опсе	핡	MD 10e. Street and Number	N/A	Ba.	ltimore 110f	Zip Code			10g. Citize	en of What Cou	
the Mar	notified at once.	Director	2836 W. North	Avenue				216			U S A	
Baltimore, MD 21215-0036  pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewie Important; If item 27 is marked offer than "matural", or items 23a or 28a-f sho	t be no		11. Marital Status 1 X Never Married 2 Married	12. Was Decedent E Armed Forces?	ver in U.				? ( Specify Yes or N Puerto Rican, etc.)	0- 1-	<ol> <li>Race - Amer White, etc.</li> </ol>	ican Indian, Black,
ter dea	r mus	ᇍ	44	1 Yes 2X	X No	1 Yes	2 <b>X</b> X No	specify:		s	pecify:	Black
ours af	amine	a p	15. Decedent's Education (Specify on	or Dates:	leted)	16a. Decedent's Usu	al Occupat	tion (Give kir	nd of work done	16b. Kir	nd of Business	Industry
6 172 hc an "na	cal Ex	ete	Elementary/Secondary (0-12)	College (1-4 or 5+	<i>'</i>	Unemp.			se retired)	Ι,	unempl	50VO
.003 within giene.	Med	Completed	12th grade 17. Father's Name (First, Middle, Last)	N/A		onemp.			Name (First, Middle			<u> </u>
215- e filed tal Hyy	nt, the	Be C	Rodney Scott						nne Will			
213 could b	tic eve		19a. Informant's Name/Relationship (T	ype, Print )				et and Numb	er or Rural Route No	mber, City	or Town, State	
MD nd 2 sh alth an m 27 i	auma	]	Lawrence Kelly- 20a. Method of Disposition	Uncle	T00+ 1	93 Cha			Circle		O CO,	MD 21236
ore, of Her If ite	ther tr		1 X Burial 2 Cremation 3	Removal from Stat	e c	crematory or other place Carmel	ice)	i	4-27-09		lto,	
tim t. Pag tment rtant:	y or 0	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen		111	22. Name a					-	MD
Bal permi Depar Impo	injur		21. Signature of Funeral Service Licen	Janes	)	- 1			March th Avenu	East ie Ba		MD 21202
Physicia	an	_	23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused to	he death.	. Do not enter the mo	de of dying,	, such as car	diac or respiratory a	rrest, shoc	ck, or heart	Approximate Interval Between Onset and
Medic xamin			Immediate Cause (Final disease a.	Methadone	e int	toxication						Death
			or condition resulting in death)	Due to (or as a consec	dneuce o	f):						
	ı	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence o	f):						
J.		Examiner	(Disease or injury that initiated C.	Due to (or as a consec	quence o	f):						
and and			d.	0.0	- 27	,28a-f, PI	T	ME of	001 5/11/	<u> </u>	<u> </u>	
<b>60,</b> ate be exc hysician	burial	Physician/Medical	X UNPENDED	-1			.ı,per	ME go	091 3/11/			
876 tificate	for use as the	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of preg	nancy <sub>2</sub> Fetal de	ath 3	Ectopic	pregnancy		. Date of delive Month	Day <b>Ye</b> ar
Box 687: death certificathe attending p	for use	sicia	past 12 months?  1 Yes 2 No 9 V Unknown	4 Pregnant at t	ime of de		Specify)					
. B. the de	detached f	Phy	Part II. Other significant conditions	J GIRIOWII	but not r	esulting in the underl	ying cause	given in Par	t I. 23e. Did	tobacco u	use contribute t	o the cause of death?
P.O es that t	8 0	اھ	Ascities, chro							'es 2 🗸	No 3 Pr	obably 4 Unknown
rds, requir been s	plnods	etec							24a. Wa	is an opsy		autopsy findings available completion of cause of
of Vital Records, ng Physician: The law require ther this certificate has been si	61	Completed							pe 1 <b>✓</b> Ye	formed?	death?	
tal Re( cian: The certificate	director, p	Be C	25. Was case referred to medical				26.Piac	I Others	Check only one)			
Vit Physical	븀		1 🗸 Yes 2 No			ER/Outpatient 3	DOA Init		Nursing Home 5	Resider		ner:
n of ding Pl h.			27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day,Ye Fd 4/17	ry ear) /∩Ω	28b Jime of Injury	)X 300. IIIJI	Yes 2 X	No unk	e now mju	ny occurred	
Division hal or Attendin rs after death.	by the	icati	2 Accident Investigati	28e Place of Init		3:30 pm ome, farm, street, fac				(Street a	nd Number or I	Rural Route Number, City
Div iital or urs after ral Di	filled in by	Certification:	3 Suicide 6 X Could not determine	be		found at	resid	lence	Balti	nore,	MD <sup>w</sup> ·	Rural Route Number, City North Ave
Division of Vital Records, P.O. Box 68760, of the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	completely fi	edical C		ian: To the best of my	knowled	lge, death occurred a	t the time, on my opinio	date and place	ce, and due to the co	te and pla	d manner as st	ated. the cause(s)
To #	com	Medi	29b. Signature and title of certifier	and manner stated.				se number				Month, Day, Year)
		-	D-all-	- ,			O.C	.M.E.		Apri	il 18, 2009	
d	1		30. Name and address of person who		eath (Iten							
<u> </u>	/		Donna M. Vincenti, MD	Assistant Medic	al Exa	miner 111 Pe	nn Stree	t, Baltimo	ore, MD 21201			
Bo	St gist		31. Date filed (Month, Day, Year) MAY 08 2009	32. Registrar		barker .						

ORIGINAL

			State of Maryland / [	Department of Health and Menta	al Hygiene
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No UU J 4 J C. Z te of Death 3. Time of Death
	Physici		Allen Dwight Wilki	Mo	Cy O2 2009 5:54 PM
· · · · · · · · · · · · · · · · · · ·	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
أتمس			Sinai Hospital OF BALTIMORE	Baltimore City	NIA
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. (Mo	e of Birth path, Day, Year)  9. Birthplace (State or Foreign Country)  Output
	Director		Usual Residence of Decedent	13.	18 1948
	yland how		10a. State 10b. County 10c. City, Town		10d. Inside City Limits
	e Mai Ba-f s	ctol	MD Baltimone x	landailstown	1 □Yes 2XiNo
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, it a Medical Everting marke	Funeral Director	10e. Street and Number	10f, Zip Code 21133	10g. Citizen of What Country?
	ns 23	eral	11. Marital Status 12. Was Decedent Ever in U.S.		es or No- 14. Race - American Indian.
9	or iter		1 ☐ Never Married 2 M Married 1 ☐ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, o	<b>D</b> 1.
5-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 Min Specify:	Specify: Black
<u>7</u>	n 72 h "natu	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Baltmore County
2121	l withii jiene. r than	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12th Qrade 5tylars	Teacher	Public Schools
٥	al Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Surname)
<u>X</u> a	should be and Mental s marked c umatic eve	2	George Wilkins, Sr.	Christine	Clark
Maryland	2 series			Mailing Address (Street and Number or Rural Route	
	s 1 and of Health item 27 other t		Eva A. Wilkins / Wife 4, 20a. Method of Disposition 20b. Place of		ndall Stown MD 21133
ē			1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Disposition (Name of y, crematory or other place)  Son Forest 05/08/06	0 4 1 11 110
Baltimore,	e intra		21. Signathre of Funeral Service Licensee	22. Name and Address of Facility	
m	Dep Imp	1, 1,	Vaush C.		Landallstown MD 21133
			23a. Part 1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or respir	ratory arrest, Approximate Interval Between Onset and Death
Mary	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Mussive in tracco	neal hemmorrhage.	Hdays
	Examiner		Due to (or as a consequence of	An area commenced in the American	No Area Hungar
	, , ,	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	lung concer with brain	metertasio years
>	ecutec nd transit	Examiner	that initiated events		
90,	cate be executed bhysician and the burial-transit		resulting in death) Last Due to (or as a consequence of	rf):	
98760	certificate be executed iding physician and se as the burial-transit	dical	d		
XOA	leath certifica attending ph for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_	23d. Date of delivery
	death ne atten ed for u	sicia	in the past 12 months?  1 ☐ Yes 2 ☐ No  1 ☐ High past 12 months?  1 ☐ High past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
7. O	w requires that the d been signed by the should be detached	Phys	9 Li Unknown	170	Bill a state of the block
Š,	ires the signer	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	e. Did tobacco use contribute to the cause of death?  1 ☑ es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Ö	v requ	etec			
ě	The law ate has b	Completed	My pes lipidamia.		a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Vital Records,	ding Physician: The law h. After this certificate has funeral director, page 2 s	BeC	25. Was case referred to medical	1 [ 26. Place of Death (Chec	□Yes 2 ☑Mo 1 □Yes 2 ☑Mo
o	Attending Physician: It death. ector: After this certific. by the funeral director.		examiner? 1 Yes 2 10 Hospital: 1 Inpatient 2 ER/Ou	Other:	☐ Residence 6 ☐ Other (Specify)
ב	ing P	Certification: To	1 ☑ Katural 5 ☐ Pending (Month, Day, Year) In	njury Work?	escribe how injury occurred
ISION	death death stor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, far	M 1 Yes 2 No	cation (Street and Number or Rural Route Number,
$\geq$	after after Direct	ertif	4 Homicide determined building, etc. (Specify)		y or Town, State)
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only 2 Medical Examiner: On the basis of examination an	, death occurred at the time, date and place, and du	e to the cause(s) and manner as stated.
	the H hin 24 the Fi	ledical	and manner stated.		
	<b>오</b> 첫 <sup>종</sup> 교	Σ	29b. Signature and title of certifier  Live Juis Pasas-Carosaon M.	29c. License number  BAS RES - COO	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (		May 02 2009
	10		30. Name and address of person who completed cause of death (Item 23a) (  LUIS A. ROSAS CANDELON MEES SIM	IAI HOSPITAL OF BAZI	TIMORE
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature		
	Registra		Juis A. Rosas - Can Delan MBB S SIN 31. Date filed (Month, Day, Year) 32 Registrar's Signature	back	
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** May 2, a.M 2009 aura 3:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital Laurel 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 216-50-5112 59 Director 22, 1949 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show a or 28a-f sh t be notified 1 ☐ Yes 2 No MD Prince Georges Bowie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20720 United States "natural", or items 23a Funeral 12919 Sutters Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2X No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Judicial System Court Room Manager 12 permit. Pages 1 and 2 should be filed i Department of Heath and Mental Hygic Important: If tem 27 Is marked other i any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Cavanaugh West Mary Babashan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Johnson 13143 Larchdale Rd. Apt.3 Laurel, MD 20708 (caregiver) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date May 6, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) : 2009 Beltsville, MD 22 Name and Address of Facility Rapp Funeral & Cremation Service 21. Sign turi 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ventricular Aneurysm /Medical Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Examiner burial-transit Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) physician Physician/Medical the attending IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1□ Yes 2√√ No certificate Respiratory Failure Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the nover within 24 hours after deam.

To the Funeral Director: After this or the funeral director after this or the funeral director. 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending (Month, Day Year) 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 2, 2009 D53235 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) 13635 Baltimore Ave. Laurel, MD 20707 Darryl A. Hill, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar MAY 08 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year · 49 AM **Physician** orae 2009 /Medical 4c. County of Death acility Name (It not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth (Month, Day, Nov 1, 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 X M 2 □ F 52 096-50-4039 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at 10a State 10b. County 1X Yes 2 □ No Director Florida Sarasota Sarasota 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò ritems 23a or USA 2713 Robinson Avenue 34232 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: White ð 3 ☐ Widowed 4 🗓 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done d life. DO NOT use retired) during most of working College (1-4 or 5+) Elementary/Secondary (0-12) Sales Computer Technology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental Hemman 17 is marked of Ludwig Wilhelm Weiss Rita Seims ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Health em 27 2713 Robinson Avenue Sarasota, Florida 34232 Randi Whitehead, Friend or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of H important: If ite any injury or ott once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/07/09 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> Completed Be Medical Certification: To

Box 68760, P.O. Division of Vital Records, Hospital or Attending within 24 hours after death

To the Funeral Director: A
completely filled in by the

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								-			24a. Was autor perfo 1  Yes			Were autopsy prior to comple death?	findings availa etion of cause ] No	able of		
25.	Was case referre	ed to medical		26. Place of Death (Check only one)														
	examiner?	No	Hospital:	ospital: Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence									6 □ Ot	6 Other (Specify)				
1	Manner of Death  Natural  Accident	5 Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Inju Wo 1 [	ork?	2 🗌 No	280	d. Describe	how inju	iry occu	rred				
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200.	Place of injury - At I building, etc. (Spec		t, facto	ory, office		_	28f	Location ( City or Tox			ber or Rural Ro	ute Number,			
298	a. Certifier (check only one)		iner: On	o the best of my kn the basis of examin														

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

**ORIGINAL** 

Box 68760, P.O.

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records. After after death Director: 24 hours a within 2 To the I

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Vear Month **Physician** P M Phillip Lawrence Webster 2009 3:05 Mav /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard 6112 Jerrys Drive Columbia If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6/27/1934 Birthplace (State or Foreign Country)
 NY 5. Social Security Number 7. Age (In vrs. last birthday) 1 X M 2 □ F Yrs. 103-28-8034 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It is Medical Exeminar mass he accessed. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1X Yes 2 □ No Director MDColumbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6112 Jerrys Drive Funeral U.S.A12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 Specify: Black 1 ☐Yes 2XNo Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Pediatrics Doctor 18. Mother's Name (First, Middle, Maiden Surname) ukn 17. Father's Name (First, Middle, Last) ukn Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Phillip Webster II / Son 6112 Jerrys Drive Columbia MD, 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cypress Hills Cemetery5/9/2009 Brooklyn, <u>New York</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Phillip A. Weatherford Funeral Services, P.A. 2431 E. Oliver Street, Baltimore, MD 21213 23a. Part1. En ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancreatic Cancer year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Parkinsons Dementia 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2K No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 ☐ Yes 2 N 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mannet 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) Medi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number MO 758747 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chartel Drive Columbia andal Kiesett GOTOS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 08 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar		Sta	te of Ma	aryland		oartmer e <i>rtifica</i> i				ental Hy	ygiene Reg. No	200	9	14927				
100			1. Decedent's Name	e (First, Middl	e, Last)				•		,		2. Date of D Month	eath Da	lv '	Year	3. Time of Death				
	Physici /Medic		Florence	Anne Y	ates							1			09		7:00 PM M				
4	Examin	_	4a. Facility Name (#	f not institution	n, give street a	nd number)			4b. City	Town, or	r Location	of Death	4c. County of Death								
		排 生	Potomac V		Nursin	g Cent	er ·					rille			ontgo						
	Funeral Director		5. Social Security No. 212-68-08		6. Sex 1 ☐ M 2		e (In yrs. la 85	ast birthda Yrs.	y) If Unde Months	Days	If Unde Hours	Min.	8. Date of B (Month, D 06/26	irth (ay, Year) (192.	) 3 E	9. Birthp Coul PA	place (State or Foreign htry)				
	D >=====		Usual Residence of 10a. State	Decedent 10b. County			100 City	, Town or	Location								10d. fnside City Limits				
	anyla •hov	-	TOA. SIAIO	TOD. County													1 ☐ Yes 2 No				
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Itema 23e or 28a-f ehow any Injury or other traumatic event, the Medical Exerts or thurst be collised at once.	y Funerai	11. Marital Status  1 □ Never Marrie		ned 1	s Decedent I ned Forces? Yes 2 1 h es, Give	Vo.		If Yes, spe	cify Cuba	an, Mexic Specif	an, Puerto F	cify Yes or Nican, etc.)	10-		, White,					
ö	ural',	Q D	3 Widowed			ar or Dates:	1944-							_							
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7	Hygid ther ther	ပိ	17. Father's Name (	First, Middle.	Last)	5+		Nuls	· · ·		18. Mot	her's Name	(First, Middl	e. Maider	Surname	)					
an	d be	Be C	Charles		· ·	18. Mother's Name (First, Middle, Maiden Surname Elizabeth Ann Pitkevicz								,							
₹	shoul nd Me mark mati	ဥ	19a. Informant's Na					19b. Ma	ilina Addres	S (Street	and Num	ber or Rural	Route Num	her City o	or Town. S	itate. Zio	own, State  Maryland				
<b>≥</b>	d 2 s th an trau		Carol Yat																		
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Baltimore, Maryland 21215-0036	Pages tment of tant: If It		1 Donation	5 Other (S	Specify)	I from State	Chesapeake Crematory 20						y 5 009								
Bal	Depar Impor any Irr		21. Signature of Fu	neral Service	Lizonovo		40038		22. Name a Rapp E 933 Gi	uner	al &	Cremat	ion Se	rvice	es arylan	na 20	910-				
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	/Medical		resulting in death)		a	ue to (or as		ience of):		, ,	INV	VC				-					
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Jan.	an ar	ŭ	resulting in death) L	ast	D	ue to (or as	a consequ	ience of):													
8760,	cate be executed physician and the burial-transit	dical			d																
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О. Вох	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending; completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent in the past 12 1 Yes 2 4 9 Unknown	months?	1 4	es, outcome Live birth Pregnant at Unknown	2 Fetal	death	B □Ectopic p □ Other (s <sub>i</sub>		<u>'</u>				23d. Date Mont		ery Day Year				
σ.	res that igned b	by Pi	Part II. Other signifi	icant conditi	ons contributin	g to death b	ut not resu	ilting in the	underlying	ause giv	en in Parl	1.	23e. Did	tobacco	use contrib	oute to t	he cause of death?				
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ta	sician: Th certificate rector, pag	BeC	25. Was case referr	red to medica	1						26 Pfa	ce of Death	(Check only		, , , ,	_ 165	200140				
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Division of Vital Records, P.O.	al or Attend after death Director:	Certification:	3 🗌 Suicide 4 🔲 Homicide	6 □ Could detern	not be nined 28e.	Pface of Initial building, etc.	ury - At ho c. (Specify	me, farm,	street, factor	y, office		2		(Street ai		r or Rur	al Route Number,				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	1 ← Certifyir 2 ☐ Medical	ng Physician: Examiner: Or an	To the best of the basis of manner sta	f examinat	wledge, de ion and/or	ath occurred investigation	at the tin	ne, date a pinion, de	and place, a eath occurre	nd due to the d at the time	e cause(s e, date an	and man d place, ar	ner as s	stated. o the cause(s)				
	To the within to the components		29b. Signature and title of certifier  29c. License number  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)  29d. Date, signed (Month, Day, Year)												Day, Year)						
	14+1		30. Name and address AYEU	ess of person	who complete	d cause of d	eath (Item	23a) (Typ	e (E Ca	las	12	. Ro	ckv	ille	M	0 8	20850				
	Sta Registr	te	<ol> <li>Date filed (Mont</li> </ol>	th, Day, Year)		32. Registra	ar's Signat	ure	21												
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar Certificate of Death Reg. No. 2 0 9 4 9 2												
	1. Decedent's Name (First, Middle, Last)					2. Date of Dea			3. Time of Death				
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al	4a. Facility Name (If not institution, give street and number)			4h City Town	Location of Death			ty of Death					
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	South River Nursing&Rehab Co			Edgewat	Ler If Under 24 Hrs.	0 Det: -4.01.11		Aruno					
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cto	Maryland Calvert	Che	sapeal	ke Beach					1 □ Yes 2 ሺ No				
ire	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	try?				
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Be Completed by Funeral Director	<ol> <li>Decedent's Education (Specify only highest grade completed)</li> </ol>		(Give k	ent's Usual Occup ind of work done	ation during most of worki d)	ing	16b. Kind of	business/Inc	lustry				
du.	Elementary/Secondary (0-12) College (1-4or 5+)				מ)								
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g.	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surna	ame)					
2	George Edward America				Agnes	Selby							
	19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	Address (Street	and Number or Rura	al Route Numbe	er, City or Tow	n, State, Zip	Code)				
	Thomas V. Adams/Son			,	ad Edgewa								
	20a. Method of Disposition					Date	20c. Location	ı - City or To	wn. State				
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State			ition (Name of atory or other place									
	4 Donation 5 □ Other (Specify)	Hill	crest	Cemeter	y 4/23	/2009	Annapol	lis,Maryland					
	21. Signature of Funeral Service Licenses							napolis,Maryland las Funeral Home					
	Ne G. ERLAN		29	973 Solomons Island Rd. Edgewater, Maryland									
	23a. Parti. Enter the disease, or complications that caused the	ne death.	Do not ente	ter the mode of dying, such as cardiac or respiratory arrest, Interval Be									
	shock, or heart failure. List only one dause on each line Immediate Cause (Final			_		Onset and Death							
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Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):													
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إ إ	IF FEMALE: 23c. If yes, outcome of		су				23d. Date of delivery						
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Medical Certification: To Be Completed by Physicia			g iii ui⊎ u∏i	acitying cause giv	on mr calli.		le. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown						
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Ö	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day,	Year) 2	8b. Time of Injury	28c. Injur Worl		28d. Describe h	ow injury occi	urred					
cati	2 Accident investigation			M 1 🗆	Yes 2 □No								
É∣	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	/ - At hom (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Nur	nber or Rura	l Route Number,				
Ce						, J. 100	,/						
ia (	29a. Certifier 1 Certifying Physician: To the best of	my knowl	edge, death	occurred at the ti	me, date and place,	and due to the	cause(s) and	manner as s	tated.				
gic	(Check only one) 2 Medical Examiner: On the basis of eand manner state	examinatio	n and/or inv	estigation, in my o	ppinion, death occur	red at the time,	date and place	e, and due to	the cause(s)				
N N	29b. Signature and title of certifier			29c. Licens			29d. Date sign	ned (Month.	Day, Year)				
7	lugar . C. J	un.	ma		50653	3	_		2009				
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<b>'</b>	30. Name and address of person who completed cause of dea	ath (Item 2	3a) (Type, P	rint) GV/	W.C.	SURA	NA	-					
	5851- Deale Chi	wid	rton	ROOM	Dec	c/e	mp	20	75/				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State amend 20,21 per hosp. g891 5/8/192akh of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2009 MORGAN LEMONT AYERS MAR 6:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 ☐ F Months Hours Yrs Director 14 MAR 2009 MARYLAND Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD MONTGOMERY CLARKSBURG 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 23511 GARDENSIDE PLACE 20871 UNTTED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐Yes 2 X No Specify BLACK Specify: ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 N/AN/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANITA MARGUENTE HENRY BRIAN LEMONT AYERS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23511 GARDENSIDE PLACE CLARKSBURG MD 20871 ANITA M.AYERS/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \$1 APZKA 4 Donation 5 Other (Specify) 4M1 F2E02KK Thousan NNIMC BETHESDA MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee National Naval Medical Center, Bethesda, MD. Frederick A. Thomason Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EXTREME PREMATURITY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 1 Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗆 No 25. Was case referred to medica examiner? Be 1 ☐ Yes 2 🔀 No 2

**Physician** /Medical Examiner

the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Physician:

Hospital or Attending

show

death with

Baltimore, Maryland 21215-0036

d other than "natural", or items 23a or 28a-f show event, the Wedlow Examination to multiled at

Je filed with

marked other Ith and Mental Hv

permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any injury or other trau

Pages 1

and burial-trar attending physician the use ō the þ signed I has page 2 certificate this After thi funeral of Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the ft.

									1 - A				
al	26. Place of Death (Check only one)												
	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA							Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
ng igation not be mined		28a.	Date of Injury (Month, Day, Year)	28b. Time of Injury	М		Injury at Work? 1 □ Yes	ury at 28d. Describe how injury occurred rik?  ]Yes 2 □ No					
		28e.	Place of Injury - At h building, etc. (Spec	ome, farm, stree	et, facto	ory, of	fice		28f. Location (Street and Number or Rural Route Number City or Town, State)				

	ledge, death occurred at the time, date and place, and due to on and/or investigation, in my opinion, death occurred at the	
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

5 Pendi

invest 6 ☐ Could

03-04-2009

Eleccaschawn, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0101241289 (VA) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

REBECCA J. CHASON

27. Manner of Death

1 XNatural

2 Accident

3 Suicide 4 ☐ Homicide

Medical



09-03408 Jeffrey Akins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rey Akins			For State	of Maryland / D	epartment o Certificate o	f Health ar f Death	nd Mental H	ygiene 	No. 20	109 14931			
Phys	siciar		egistrar . Decedent's Name (First, Middle,Las	it)				Date of Death     Month Da	ay Year	3. Time of Death 2328 hrs			
Filys احمنام		er	Jeffrey M. Aki	ns				Month Da April 27, 200	9				
		4	a. Facility Name (if not institution, given 7600 Block of New Horizon)			4b. City, Town, o Frederick	r Location of Death		4c. County of Deat Frederick				
Fune	ral	5	. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Ye			MM/DD/YYYY) 9. Bi Forei	ign			
Direc			161-58-8792	ζ M 2 F	46 Yr	Months Da	ys Hours Mir	March1	4,1963 °	ountryPennsylvan			
			Isual Residence of Decedent							10d. Inside City Limits			
Š	amà	_	0a. State 10b. County	100	c. City, Town or Loca	ition				1 Yes 2 X No			
p q	e 9	- N	arvland Mont	gomery P	otomac								
arylar	at on	읈	Oe. Street and Number			10f. Zip Code		109.	Citizen of What Co	untry?			
he M	ified	Director	10001 Crestle	igh Lane		20854			S.A.	- Start			
with	e no		11. Marital Status	12. Was Decedent Eve	er in U.S. 13. W	as Decedent of h	Decedent of Hispanic Origin? ( Specify Yes or No- s, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.						
Jeath	n rten	Funeral	1 Never Married 2X Marrie	1 Yes 2 X	No				Specify: Wh	i to			
ıller (	ner n	ᅀ		d If Yes, Give Year or Dates:		Yes 2 X		work done	6b. Kind of Busines				
ours	xami	ᇍ[	15. Decedent's Education (Specify		during	most of working l	oation (Give kind of ife. DO NOT use re			velopment&			
<b>6</b>	ea E	흵	Elementary/Secondary (0-12)	College (1-4 or 5+)	i				Construc	- 1			
within	Med a	Completed	17. Father's Name (First, Middle, Las	44	TACCO	<u>untant</u>	18.Mother's Nan	ne (First, Middle, Ma					
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene	the the							M. Mye					
21215-0036 buld be filed within 7 Mental Hygiene	even	e Be	Gerald T. Aki 19a. Informant's Name/Relationship	NS (Type, Print )	19b. Mail	ing Address (St	reet and Number o	Rural Route Numb	er, City or Town, Sta	ate, Zip Code)			
D sh B	7 is n	۲	Dashelle B. A		178	15Steel	Horse	Road.Co	rnelius	N.C. 28031 or Town, State			
and 2	trauf	ŀ	20a. Method of Disposition			osition (Name of	cemetery,	Date	20c. Location - City	or Town, State			
Ore	ther I	- 1	1 Burial 2 X Cremation				5-	1-09	Baltimo	re,Maryland			
Baltimore, permit. Pages I a	rtant y or o	Ļ	4 Donation 5 Other Speci 21. Signature of Funeral Service Lic	fy:	Bayview 22	. Name and Addr							
Bal permi Depar	injur.		9.1.1.19	1.06	6	009 Hai	ford Ro	ad, Balt	imore, Ma	Chapel, P.A. aryland21214			
		-	23a. Part I. Enter the disease, or con	mplications that caused th	e death. Do not ente	r the mode of dyi	ng, such as cardia	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and			
Physic March			failure. List only one cause on	each line. a. <b>Asphyxia</b>						Death			
.am	iner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	uence of):								
		- 1	Sequentially list conditions,	b. Inhalation of Heliu									
		힐	if any, leading to immediate	Due to (or as a conseq	uence of):					-10			
		Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								
nted	nd transit	ŭ	events resulting in death) Last	d									
executed	an an al - tr	dical	UNPENDED	AMENDED									
<b>60</b> , ate be	attending physician and for use as the burial - trae		IF FEMALE:	23c. If yes, outcome	e of pregnancy				23d. Date of deli	very Day Year			
Records, P.O. Box 68760 The law requires that the death certificate I	ling p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at ti	me of death	Fetal death	3 Ectopic pre	gnancy	Month	Day 100.			
ath ce	for use	sici	1 Yes 2 No 9 Unkno		me of death 5	Other (Specify)							
He de	9 P	Phy	Part II. Other significant condition	Land 1	but not resulting in t	he underlying cau	se given in Part I.	23e. Did to	bacco use contribut	e to the cause of death?			
P.O.	signed by the	þ		•				1 Yes	2 V No 3	Probably 4 Unknown			
ls, l	en sig uld be	Completed						24a. Was		re autopsy findings available r to completion of cause of			
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Zec The t	cate	Ö					Place of Death (Ch		2 <b>V</b> No 1	165 2 1.0			
of Vital Records, ng Physician: The law requir	nis certificate director, page	Be (	25. Was case referred to medical examiner?	Hospital:			Other:	ursing Home 5	Residence 6	Other: Scene			
of Vital	his	10	1 🗸 Yes 2 No	I Inpatier			. Injury at Work?	28d Describe	how injury occurred				
	After 1 funeral		27. Manner of Death  1 Natural 5 Pendir	28a. Date of Injur (Month Day Ye Apr 27, 2009			Yes 2 ✔ No	Subject pur	posefully inhale	ed helium gas			
itend tend		atic	1 Natural 5 Pendir 2 Accident Investi	ig - ction	ury - At home, farm,			28f. Location (	Street and Number	or Rural Route Number, City			
Division tal or Attendi	Director:	ti Ei	3 ✓ Suicide 6 Could	not be			nce bananig, etc.	or Town, \$	State) f New Horizon Wa	ay, Frederick, MD			
Di the Hospital	neral Dir filled in	Certification:	4 Homicide determ		king Lpt in vehi	secured at the tin	ne date and slace	and due to the cau	se(s) and manner as	s stated.			
E Ho	To the Fur completely		29a. Certifier 1 Certifying Phy one) 2 Medical Exam	rsician: To the best of my	/ knowledge, death on hination and/or inves	stigation, in my of	pinion, death occur	red at the time, date	and place, and due	e to the cause(s)			
Toth	To the Funeral I completely filled	Medical	2 Medical Exam	and mariner stated.			icense number		29d. Date signed	(Month, Day, Year)			
	. 0	Σ	29b. Signature and title of certifier				O.C.M.E.		April 28, 200	9			
			NUN	IM			.,						
			30. Name and address of person v		eath (Item 23a)	111 Dann C+	reet, Baltimore	MD 21201					
			Donna M. Vincenti, MD					, 1410 2 1201					
		tate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	park	1						

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MARGARET LOUISE ANDREWS 2009 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1221 Baldwin Mill Road Harford Jarrettsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 18, 1 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2**X** F 217-64-1545 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD. Harford Jarrettsville 10e. Street and Number 10g. Citizen of What Country? o e 21084 ral", or items 23a Examiner must b 1221 Baldwin Mill Road United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death \u00e4nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify Specify: 3 Widowed 4 □ Divorced "natural", Year or Dates: White the M diral 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Title Elementary/Secondary (0-12) College (1-4or 5+) Senior Certifier Administration item 27 is marked other other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles 2 Arthur Gloria Jean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Stefani Andrews (Daughter) 1221 Baldwin Mill Rd. Jarrettsville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: if its any injury or o once, 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Bethel 5/6/2009 Madonna, Maryland Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final Due to (or as a consequence of) Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 ☐ Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has irector, page 2 death? 1 🗌 Yes 1□ Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔲 🎉 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide within 24 hours at To the Funeral D completely filled 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who complet

Year)

DHMH 17 Rev 1/2001

20

DK

cause of death (Item 23a) (Type, Print)

32. Registrar's

29d. Date signed (Month, Day, Year)

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			State Registrar  1. Decedent's Name (First, Middentification)	fle, Last)			Cei	rtificate	of L	Death		2. Date of D	Reg. No eath			me of Death
• 2	Physici /Medio		Kathryn Beard									April	18,	2009	1:	55 p <sup>M</sup>
	Examir		4a. Facility Name (If not institution HTLLHAVEN NUI					4b. City, To	own, or LPH		of Death		4c. County of De			GE'S
	III DELITATION OF THE PROPERTY											12	Birthplace (S Country) OHIO	ate or Foreign		
460	Sagara en sanciament		Usual Residence of Decedent							1						
	Marylan -f show lied at	tor	MD PR	y INCE GEO	RGE'S	10c. City, T	OELPH									de City Limits ]Yes 2 <b>∑</b> No
	h with the 3a or 28a st be notif	Funeral Director	10e. Street and Number 3210 POWDER M.	ILL ROAI	)			10f. Zip C					_	J.S.A.	Country?	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funera	11. Marital Status  1 □ Never Married 2 □ Ma 3 ※Widowed 4 □ Divorce	rried 1 [	s Decedent Ined Forces? Yes 2 7			Was Decede If Yes, specif 1 ☐ Yes 2		ispanic Or an, Mexica Specify		ecify Yes or N Rican, etc.)	0-	Black, V	American Indi Vhite, etc. WHITE	an,
2-00	72 hou 'natura dical E		15. Decede (Specify only high	ent's Education est grade comp	leted)		(Give	dent's Usual	done o	durina mos	st of work	ing	16b. I	Kind of Busine	ess/Industry	
Maryland 21215-0036	d within jiene.	Completed	Elementary/Secondary (0-12)	Col	lege (1-4or 5	5+)		DO NOT use MEMAKE		1)				HOME		
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ryla	12 should be filed w h and Mental Hygie 7 is marked other th rraumatic event, th	은	SIDNEY B. GILI		nt)		19b. Maili	ng Address (	Street		OSSI	E MCCF al Route Num			te, Zip Code)	
	and 2 sealth ar		19a. Informant's Name/Relation BELL NANCY F. BEAR	→ / DAUC	SHTER		2410	ARROW	HEA		AD, 1	PORT RI	EPUBI	LIC, M	206	76
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 【ACremation		I from State	cem	netery, cre	osition (Name matory or oth	ner plac	Ł.		Date		Location - City		
altin	mit. Pa partme sortant / Injury	1	4 □ Donation 5 □ Other of 21. Signature of Funeral Service			METR	and the second second	TAN C	Addre	ss of Facil	itv	HOME,	,	ALEXAN	DRIA,	VA
ä	Depar Impor any ir	Ö Ü	Urang &		house		1/8	202 G	REE	ENE S	TREE	r, cumi	BERL	AND, M		
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	Physician /Medical Examiner		disease or condition resulting in death)			vascus a consequer		ccider	ιτ						1 w	
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68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours aller death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner												days		
P.O. Box (	requires that the death certificate be een signed by the attending physicis hould be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □										23d. Date of delivery Month Day Year			
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Division or Vital Records,	: The law recate has been; page 2 sho	Completed						·				1□ Yes	opsy formed? 2	dea	re autopsy fin r to completion th? Yes 2 \( \square\$	dings available on of cause of
Zi.	sician certif	o Be	25. Was case referred to medic examiner? 1 Yes 2 No	cal Hospita	l: 1 □ Innatie	ent 2□FF	3/Outpatie	nt 3□ DO/	Oth	or /	/	th <i>(Check onl)</i> ome 5 ☐ Re		6 ∏Other	(Specify)	
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Division	al or Attendar al er death I Director: d in by the	Certification:	3 Suicide 6 Coul	d not be rmined 28e	. Place of inj building, et	jury - At hom tc. (Specify)	e, farm, st	treet, factory,		100 22	1110	28f. Location City or T	(Street a own, Sta	and Number ( ate)	or Rural Rout	e Number,
	To the Hospital or within 24 hours af e To the Funeral Dir completely filled in it	Medical C	29a. Certifier 1 → ertify (Check only one) 1 → Medic	ying Physician: al Examiner: O ar	To the best n the basis o d manner st	of examinatio	edge, dea nn and/or i	th occurred a	it the ti in my	me, date a opinion, de	and place eath occu	, and due to the time	ne cause e, date a	(s) and mann and place, and	er as stated. I due to the c	ause(s)
	To th To th	ğ	29b. Signature and title of cert	19					Licens	se number			l	pate signed (/		
	15		30. Name and address of person	on who complete	~	death (Item 2	3a) (Tvoe							CTT T	., 2003	
	nss		Thomas Masle		, 7525	Green	nway	Center	Dı	cive,	Gre	enbelt	, MD	2077	0	
70.0	St Regist		APR 2 4 20	09 Ben	32. Registr	rar's Signatu	arke	1								

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vea **Physician** APRIL 12:20 AM Leon 20 2009 Bannister /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAPLATA CIVISTA MEDICAL CHARLES CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
July Day, 7 , 1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 214-68-8977 52 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Md Charles Nanjemoy 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Oak 3715 Grove Place 20662 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Never Worked None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Bannister Angeline Payton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Dinkins/Sister 6740 Pauline Ct., Bryans Rd., Md., 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oak Grove Bapt. Ch. 4/25/09 Nanjemoy, Md. 4 ☐ Donation 5 ☐ Other (Specify) MOISOT 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bluford Funeral Service 2019 MLK Ave., SE., Washington, 20020 DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause into U defining Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 2 ANO 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: Ampletely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ 0050883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20646 , NeSa 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 4 2009 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year APRIL 22, **Physician** 04:00P M HOWARD ARTHUR BROWN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KENT CHESTERTOWN CHESTERTOWN NURSING & REHAB. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/27/1913 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1**X** M 2□ F MD 96 216-30-1418 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Experiment must be rediffical at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director CHESTERTOWN MD KENT 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 8473 GARFIELD LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HORSETRAINER/HUNSTMAN HORSETRAINING 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY ELIZABETH BRUELL WILLIAM MILKER BROWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 121 KIRBY RIVER RD. MILLINGTON, MD 21651 RICHARD L. BROWN/SON 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTERTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) CHESTER CEMETERY 4/27/09 21. Signature of Euneral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Kick & 130 SPEÉR RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that consed the death. shock, or heart failure. List only one cause on faciline. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2☐NO 3☐ Probably 4☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed? 1 ☐Yes 2 ☑No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. May of Death Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation n 24 hours after death.

Reference Funeral Director: Af olderely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 ho

To the Fune

completely f 0

> State Registrar

29b. Signature an

Date filed (Month, Day, Year)

and manner stated

Rundo Sta 5 Cl

29c. License number

0060301

29d. Date signed (Month, Day, Year)

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		1 - State of Maryla Registrar	•	tificate of Death		Reg.	0000	14935
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Exami	iner	4a. Facility Name (If not institution, give street and number)  CHESTER RIVER HOSPITAL CENTER		4b. City, Town, or Location of CHESTERTOWN	oi Deam		KENT	•
Funera			s. last birthday)	If Under 1 Year   If Under	24 Hrs. 8. [	Date of Birth (Month, Day, Ye		place (State or Foreign intry)
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and		Usual Residence of Decedent  10a. State 10b. County 10c. C	City, Town or Loc	ation				10d. Inside City Limits
Maryli -f sho	ģ	MD QUEEN ANNE'S CRI	UMPTON					1 X Yes 2 □ No
n the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?
th with	alD	407 THIRD STREET		21628			USA	
IIIU Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, I'n Medical Eyrit in a nather	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Or Yes, specify Cuban, Mexicar □Yes 2 1 No Specify:		Yes or No- an, etc.)	14. Race - Amer Black, White Specify: WH	
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Id be Mental rked o	To B	GEORGE DREWS		ANNA	A STANG			
OTE, Marylari ges 1 and 2 should be t of Health and Menta If item 27 is marked or other traumatic ev	-	19a. Informant's Name/Relationship (Type. Print)	4	g Address (Street and Numb				
and and salth		RAMONA J. VICKERS/DAUGHTER		BELL ROSE LAN	NE CHES		. Location - City or	
Pages 1 nent of H ant: If ite ury or ot		1 Burial 2 M Cremation 3 L Hemoval from State		sition (Name of natory or other place)			TEVENSVIL	
Deficiency of the parameter of He important; if item any injury or oth	ė	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		E CREMATION 4  Name and Address of Facili ELLOWS, HELFE				
permit. Departi	310	> Kuk S. Helfelin	$\mathcal{I} = \begin{bmatrix} 1 \end{bmatrix}$	30 SPEER RD.	CHESTE	RTOWN,	MD 21620	
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pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):					
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DIVISION OT  I or Attending Physafter death. Director: After this a in by the funeral di	Cartification. To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	t home, farm, str ec <i>ify)</i>	eet, factory, office	28f.	f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
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8.		30. Name and address of person who completed cause of death (	Item 23a) Type,	SPERIN PLD S	DE	CHA	5/188 171	on IN
m,	State	31. Date filed (Month, Day, Year). 32. Registrar's Si			103	V110	010-10	~
Regi		99 (1928) 97.	. 1. 4	Sant)				

Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of erson who completed cause of death (Item 23a)

Jack Titus MD. 31. Date filed (Month, Day, Year)

State Registra

O.C.M.E.

May 3, 2009

### **Physician** /Medical Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ns 23a or 28a-f shov event, the Medical Examiner

Baltimore, Maryland 21215-0036 Be ROBERT A. MORGAN ပ 19a. Informant's Name/Relationship (Type. Print) partment of Health a portant: If item 27 Is I injury or other trau JOHN P. MORGAN / NEPHEW 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine executed Box 68760. attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No P.O. 9 Unknown Division of Vital Records. 2 Completed 25. Was case referred to medical examiner? Be Hospital: 1 Yes 2 ☑ No Certification: To ours after death.

neral Director: After this
filled in by the funeral di After this 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide 24 hours a 29a. Certifier Medical (Check only one) 24 within 2. the 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes 24 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ELLEN F. CARPENTI 2009 5:45 AM 20 APRIL 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2 💢 F 215-26-9503 81 NOV. 20,1927 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2X No **CUMBERLAND ALLEGANY** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 U.S.A. 10301 CHRISTIE ROAD, N.E. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14 Race - American Indian 1 Yes 2 T If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify. 2 Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELLEN BURNS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 McKINLEY AVENUE, CUMBERLAND, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State SS.PETER & PAUL CEM. CUMBERLAND, MD 04/25/2009 22. Name and Address of Facility
UPCHURCH FUNERAL HOME
202 GREENE STREET, CU CUMBERLAND, MD 21502 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASPIRATION PNEUMONIA DAY Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 1 ☐ Yes 2 7 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2009 D36766 VIK POONAI, 924 SETON DRIVE, CUMBERLAND, 21502 32. Registrar's Signature action **ORIGINAL** 

DHMH 17 Rev 1/2001

State

Registrar

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Physician   Middleal Examiner   Physician   Middleal Examiner   Physician							th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rest,		Interval Between
Due to (or as a consequence of):	in a	Physician		Immediate Cause (Final disease or condition			BROW	ASCULATI	2 Acc	LINEN	_		Onset and Death
Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I.    FEMALE: 23d. Date of delivery month pay 12 months?   1	-			resulting in death)	Due to								
The state of the s		Laummer	7	Sequentially list conditions,	b	for as a conse	wience offi:						
Second Column   Second Colum		uted d ansit	min	cause. Enter Underlying Cause (Disease or injury									
Section   Comparison   Compar	oʻ	exec an an		resulting in death) Last	Due to	(or as a consec	quence of):						
25. Was case referred to medical examiner?    1	376	ate be hysicia he bu	ical	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	d								
25. Was case referred to medical examiner?    1	<u>څ</u>	ertific ling p e as t	Med	IF FEMALE:	000 16					-			
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25. Was case referred to medical examiner?    1	σ <u>.</u>	ned by deta		Part II. Other significant condition	ns contributing to o	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use c	ontribute to t	the cause of death?
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29a. Certifier (Check only one) 1 Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number D26907 April 20, 2009	/isi	Atten r deat sctor; by the	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place	e of Injury - At h	ome, farm, sti			28f. Location (	Street and Nu	mber or Rui	ral Route Number,
296. Signature and title of certifier  D26907  April 20, 2009	ă	s afte	Sert	4   Homicide	Dullo	aing, etc. (Spec	ny)		4	City or Tol	vn, State)		<u> </u>
296. Signature and title of certifier  D26907  April 20, 2009		Hospit 14 hour Funera tely fills		(Check only 2 Medical E	xaminer: On the	basis of examin							
3 D26907 April 20, 2009		the string the string	Med		and mai	nner stated.		29c. Licens	se number		29d. Date sig	ned (Month	i, Day, Year)
				•	14.								
	•	3		30. Name and address of person v	vho completed cau	use of death (Ite	m 23a) (Type,	Print)					
MAS Harjit S. Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, MD 21502	_	mas				I.D., 9	25 Bis	hop Walsh	Road, C	umberla	nd, MD	2150	)2
State Registrar  31. Date filed (Manth Pay, Year) 2009  32. Registrar's Signature				31. Date filed (Month Pay, 2 eq.)	2009 1	Registrar's Sign	d. Sa	Med					

09-03030 <del>Charles Flecher</del>	Clo	Please Type	e or Print in Black In Amend I Lem / Pel ite of Maryland / Depa	delible k	ik, Ensure Health and	All Gopie	s Are Leg	ible. 2 (	009 1493
		1- For State Registrar		tificate of				g. No.	
Physici Medical Exami	an/	Decedent's Name (First, Middle, CHARLES FLETCHE	. ,				2. Date of Death Month April 15, 20	Day Year 009	3. Time of Death 2019 hrs
		4a. Facility Name (if not institution, Sudlersville Cemetary I	-		4b. City, Town, or I Sudlersville	Location of Death		4c. County of D Queen Ann	
Funeral Director		,	6. Sex 7. Age (In yrs. la	st birthday) Yrs	If Under 1 Year Months Days		8. Date of Birth	F	Birthplace (State or oreign Country) MD
any		Usual Residence of Decedent  10a. State 10b. County		Town or Locat	ion		372=7		10d. Inside City Limits
<b>*</b>	ctor	MD QUEEN  10e. Street and Number	ANNE'S SUDI	LERSVII	LE 10f. Zip Code		10	g. Citizen of What	1 Yes 2 X No
vith the Maryland s 23a or 28a-f show notified at once.	I Director	511 BAXTER RD.			21668			USA	-
fter death wit I", or items 2	y Funeral	11. Marital Status 1 Never Married 2 XMar 3 Widowed 4 Divo	rried Armed Forces?  1 Yes 2 X No orced If Yes, Give Year	If Y	is Decedent of His les, specify Cuban Yes 2 X No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)	White, e	merican Indian, Black, tc. VHITE
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health is and Hagine in the Maryland important. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Speci Elementary/Secondary (0-12) 1.2	ify only highest grade completed)  College (1-4 or 5+)	during m	nt's Usual Occupation of working life.	DO NOT use reti		16b. Kind of Busin	·
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica	Be	17. Father's Name (First, Middle, L CHARLES FLETCH)		1100-01		18.Mother's Name	(First, Middle, M		
MD 21 nd 2 should alth and Me m 27 is mar	2	19a. Informant's Name/Relationshi SANDRA CLOUGH			- '			MD 21668	
Baltimore, Poemit. Pages I and Department of Healt Important: If item injury or other training or othe		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other Spe	3 Removal from State	rematory or ot	sition (Name of cer her place) [LLE CEME		Date / 19/09	20c. Location - Ci	ty or Town, State
Baltii permit. Departm Importa		21. Signature of Funeral Service L  Jason Fellows	Licensee	Êi	Name and Address	LFENBEIN	N & NEWN	AM FUNERA MD 21620	AL HOME
Physician /Medical xaminer			complications that caused the death. on each line.	Do not enter t					Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkr	4 Pregnant at time of de	2 Fe	etal death 3 [ ther (Specify)	Ectopic pregna	ancy	23d. Date of de Month	livery Day Year
F.S. es that the signed by t	ð	Part II. Other significant condition	ons contributing to death but not re	esulting in the	underlying cause g	given in Part I.			te to the cause of death?  Probably 4 Unknown
Division of Vital Records, rail or Attending Physician: The law requires after death.  al Director: After this certificate has been seen the funeral director, page 2 should led in by the funeral director, page 2 should	Completed				00 Fi		1 🗸 Yes	rmed? dea	re autopsy findings available or to completion of cause of oth?  Yes 2 No
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on of ending P sath. or: After the funera	ition: T	27. Manner of Death  1 Natural 5 Pendi		28b. Time of 1949 hrs		ry at Work? Yes 2 No		how injury occurred to-fixed object	
Division spital or Attentours after death erral Director:	Certification:	3 Suicide 6 Could	28e. Place of Injury - At he mined (Specify) Field	ome, farm, stre	et, factory, office b	building, etc.	or Town, S		or Rural Route Number, City Sudlersville, MD
Divisior  To the Hospital or Attend within 24 hours after closers To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph	nysician: To the best of my knowledge						
32	Me	29b. Signature and title of certifier	and manner stated.  Hell oan		29c. Licens			29d. Date signed April 16, 200	(Month, Day,Year) 9
30		30. Name and address of person v	who completed cause of death (Item	23a)					

State Registrar DHMH 17 Rev 1/2001 OCME 2006 111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

strar's Signature

Carol Allan, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4/23/2009 **Physician** Harry Pattey Calhoun 4:38  $a^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 510 William St. Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. **1**∕ M 2 □ F 92 220**-**03-4002 1/6/1917 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Ever inter the netitied at Director MD XX Yes 2 ☐ No Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 William St. 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 □ No 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 2 No White Specify If Yes, Give Year or Dates <u></u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Barber Hair Cutting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin Calhoun Helen Pattey ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9501 Abaco Lane, Ocean City, MD 21842 Reese Cropper, III/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 Removal from State Paul's Episcopal: 4/26/2009 4 Donation 5 ☐Other (Specify) Berlin, MD Burbage Funeral Home 108 William St. ma Berlin, MD 21811 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy ₽ in the past 12 months? Month Year 5 Other (specify) ed by the a 1 □Yes 2 □No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ icate has been sig ; page 2 should b 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 12 No certificate 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) After this Certification: To 27. Manny of Death funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation within 24 hours after deau.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tille of certifier 29d. Date sittined (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

2009

32 Registrar's Signat

Year)

2

Mary Collins			e or Print in								gibie.	200	19 1494
	ωm	I-For State #8, per	ate of Maryla	ind / Depa	artment of	<del>riealth</del> Death	and	Wente	ii Hyg			<u> </u>	77 1474
Physicia	n/	Registrar  1. Decedent's Name (First, Middle	e,Last)	/ 24/095	Timodio or	Dodan	E . 1	, WC.	2.	Date of Deat			3. Time of Death
Medical Examin	er	Mary Ann Collin	ıs							Month April 20, 2	Day 009	Year	1425 hrs
		4a. Facility Name (if not institution	n, give street and nu	mber)	4	b. City, Tow		ocation of	Death			ounty of Deat	h
	4	12626 Sunset Avenue		7 4 /1 1		Ocean (		If Under:	0411	0 Date of Rin		rcester	rthplace (State or
Funeral Director	- 1	5. Social Security Number	6. Sex	7. Age (In yrs. I			Days	Hours	Min.	Aug.	31,	<b>949</b> Forei	gn
		217-48-3136 Usual Residence of Decedent	1M 2_XF		Yrs.					Aug.	) 1 <b>,</b> 2	.009	ountry) Maryland
an y	ŀ	10a. State 10b. County		10c. City	, Town or Location	on				-			10d. Inside City Limits
and show	اة	Maryland Worce	ster	000	ean City								1 Yes 2 X No
Maryl: 28a-f	Director	10e. Street and Number				10f. Zip Co	ode		·	1	0g. Citizer	of What Cou	untry?
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ter des	₫		1 Yes orced If Yes, Give Yes	2 X No	1	Yes 2 X	No	specify:			Sr	ecify: Wh	nite
urs af	흵	15. Decedent's Education (Spec	or Dates:		16a. Decedent	's Usual Oo	cupation	n (Give kir				d of Business	
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2 a 8 a 5		John Motsko 19a. Informant's Name/Relations	nip (Type, Print )		19b. Mailing	Address (		Mary and Numb			nber, City	or Town, Stat	te, Zip Code)
MD and 2 shot alth and m 27 is an matic		Michael Collins	/ Son		12626	Sunse	t Av	venue	Uni	lt #5,	0cea	n City	, MD 21842
re, l I and F Healt Fitem	-	20a. Method of Disposition  1 Burial 2 X Cremation	2 Damoual fr		Place of Disposi crematory or oth	tion (Name				Date	20c. Lo	cation - City c	or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other So		OIII Otate	oe Helop		em.		4/23	3/09	Fra	nkford	l, DE
Salti ermit. epartm nports jury c	1	21. Signature of Funeral Service		1	22. N	ame and Ad	ldress o					1 Home	
	-1	Under	Cas	Ca	10	8 Wil	liar	ns St	reet	, Ber	lin,	Maryla	nd 21811 Approximate Interval
Physician /Medical	ı	23a. Part I. Enter the disease, or failure. List only one cause	on each line.				ayıng, sı	uch as car	ralac or r	espiratory arr	est, snock	, or neart	Between Onset and Death
caminer	ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Complication	ons Of Chro		Abuse					_		Death
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	ie.	if any, leading to immediate cause. Enter Underlying Cause		consequence	of):								
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Box 68760 e death certificate b the attending physi		IF FEMALE: 23b. Was decedent pregnant in th		outcome of preg		al death	3	Ectopic	oregnand	:v		Date of delive Ionth	ery Day Year
x 68 h certi tendin	icial	past 12 months?	4 Pregr	ant at time of d	oath	er (Specify		Lotopic	program	.,	1		Day You
Bo le deat the at	hys	1 Yes 2 No 9 V Unk	9 OIIKII										
that the ned by detach	Dy D	Part II. Other significant condit	ions contributing to	o death but not	resulting in the u	nderlying ca	ause giv	en in Parl	t I.				to the cause of death?
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Division of Vital Records, P.O. Box 68760, In or Attending Physician: The law requires that the death certificate b is after death.  31 Director: After this certificate has been signed by the attending physicial in the funeral director, page 2 should be detached for use as the bur	8	25. Was case referred to medical examiner?	Hospital	Inpatient 2	ER/Outpatient		10	of Death (0 other		Home 5	Pasiden/	ce 6 🗸 Oth	ner: Scene
of Vijing Physical After this	음	1 ✓ Yes 2 No 27. Manner of Death		of Injury n, Day,Year)	28b. Time of Ir			at Work?		8d. Describe			ici. oddie
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ivision or Attenc after death Director:	<u>i</u>		stigation 28e. Plac	e of Injury - At h	nome, farm, stree	t, factory, o	ffice bu	ilding, etc	. 2			Number or F	Rural Route Number, City
Dipital ours a ceral I	Certification:	4 Homicide deter	mined (Specify)							or Town,	state)		
			nysician: To the bes										
To th withii To th	Medical	one) 2 Medical Example of certifie	and manner s	or examination a stated.	and/or investigati				urred at 1	me ume, date			fonth, Day, Year)
	2	29b. Signature and title of certifie				- 1	ucense D.C.M	number				ate signed (N 21, 2009	nontin, Day, rear)
		Yaneh ?)	umall,	M)	m 22.0\		J.J.IV				, .p.		
ET 6		<ol> <li>Name and address of person Pamela E. Southall, N</li> </ol>		se of death (Iter Medical Exa		1 Penn S	treet,	Baltimo	ore, MI	O 21201			
Sta	ite	31. Date filed (Month, Day, Year)		gistrar's Signat									
Registr		APR 2.4	2009 1	me	A pa	Kel				_			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH G891 5/12/09 WS
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year М 2009 21:59 Shirley Clark-Robinson April 16, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Clinton Prince George's Southern Maryland Hospital If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex Months Days Hours 1 □ M 2 🖺 F 77 12/13/1931 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Prince George's Camp Springs 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 7112 Westhaven Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Education/ Public School Elementary/Secondary (0-12) College (1-4or 5+) 12 6 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leroy Shannon Pearl Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11103 Marisa Ct., Mitchellville, MD 20721 Sheila V. Clark/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Domation 5 □ Other (Specify) :04/25/2009 | Brentwood, MD Lincoln 22. Name and Address of Facility Strickland Funeral Services 21. Sign Jure of Funeral 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part . Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Vear Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

physician

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this certificate

within 24 hours after death.

To the Funeral Director: Af

**Physician** 

Examiner

Funeral

Director

28a-f show

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items 2

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and 2 should be filed within ealth and Mental Hygiene. m 27 is marked other than '

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permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau

Director

Funeral

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Completed

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other traumatic event, the Medical Executive quest be petitied at

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

10a State

MD

Examiner

The law requires that the death certificate be executed

Box 68760,

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of Vital Records,

Division

the Hospital or Attending

burial-tran Physician/Medical the aftending p signed by the ad be detached for ð Completed cate has l page 2 s Be 2 After thi funeral of

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 X No 9 Unknown

> 24a. Was an autopsy perform 1 ☐ Yes \_2

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 ☐ Could not be determined

Hospital: 1 🔲 Inpatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

the completed cause of death (Item 23a) (Type, Print)

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 S

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0	J	at 18	-4	J	hugh	٩

			Registrar		Cei	tificate of	Death		Reg. No.		
	Dhysia	ion	1. Decedent's Name (First, Middle, Li Eula Mae C	cleveland				2. Date of Dea Month		3. Time of Death	
	Physic /Medi		Eula Mae C	reverand		April 22, 2009  4:00					
	Exami		4a. Facility Name (If not institution, gi				or Location of Death		4c. County of	Death	
			P.G. Hospital			Cheve			P.G.		
	Funeral Director			Sex 7. Age 1 ☐ M 2 🔀 F 8	(In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug 25	<sup>1</sup> , 1 <sup>2</sup> 927	9. Birthplace (State or Foreign Country) Virginia	
	PL ,		Usual Residence of Decedent								
	arylar show	_	D C 10b. County		10c. City, Town or Lo Washingt					10d. Inside City Limits	
	8a-f	ecto			wasning					1 📉 es 2 ☐ No	
	hours after death with the Maryland tural", or items 23a or 28a-f show all Examinat must be notified at	Completed by Funeral Director	10e. Street and Number rst 1146 First	Street NW		10f. Zip Code 2000	1		10g. Citizen of Wr	•	
	ms 2	nera	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Vas Decedent of F	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		- American Indian,	
)	after or ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		t Yes, specity Cub. I∐Yes 2⊠No		Rican, etc.)		White, etc.	
	ral",	d by	3  ☑ Widowed 4 □ Divorced	Year or Dates:		LIYes 2LALINO	<i>Specify:</i>		Specify:	Black	
212-000	72 h "natu	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	lent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Kind of Busi	ness/Industry	
į	within ene. than	E	Elementary/Secondary (0-12)	College (1-4or 5+			Steward		AMD Co	Ffoo Commons	
	Hygi Hygi ther int, II		17. Father's Name (First, Middle, Las	t)	01110	on onop	18. Mother's Name			ffee Company	
	should be filed within and Mental Hygiene. s marked other than " umatic event, the Mer	To Be	Chet Saunder				Annie		maiden damame,		
	tand 2 short Health and I tem 27 is ma other trauma		19a. Informant's Name/Relationship Hugh J. Beins	(Type. Print) - Attorne	y 19b. Mailin	g Address (Street 5 Mass.	and Number or Rui	ral Route Numbe V Washi	er, City or Town, S ington , I	tate, Zip Code) D . C . 20036	
Calcillors, maryland	8 0 = -		20a. Method of Disposition  1 □ 6urial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		20b. Place of Disportant Compton (Compton)	sition (Name of natory or other place Olivet	ce) I	Date L28,09		ity or Town, State	
;	permit. Page Department Important: If any Injury or once.		21. Signature of Runeral Service Lice	nsee Rubin	22 R	Name and Addre	ess of Facility Funera	l Home	1313 <sup>D</sup> 6	C. 20001 th ST.NWWash	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused t	he death. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between	
	hysician		Immediate Cause (Final disease or condition		eral Pne	umonia				Onset and Death	
	/Medical		resulting in death)	Due to (or as a	consequence of):					-	
	Examiner		Sequentially list conditions	Chron	ic Obstr	uctive	Lung Dis	sease			
	sit sit	Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of).						
	ecut and I-tran	Хаш	that initiated events resulting in death) Last	C	tension					<u> </u>	
٥٠ ١٥٥ م	ith certificate be executed ending physician and use as the burial-transit			Due to (or as a	consequence of):						
	tificat g phy as the	in/Medical		<b>u</b>							
5	endin use	\r	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnancy	1=			23d. Date	of delivery	
;	at the deatl I by the atte stached for	Physicia	in the past 12 months? 1 □ Yes 2 ĀNo 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	ime of death 5	Ectopic pregnand   Other (specify) _	:у		Mont	h Day Year	
	hat th od by Jetacl	듄	Part II. Other significant conditions	contributing to death but	not reculting in the un	dorlying gayno giv	on in Port I	220 Did to	haces use contrib	oute to the cause of death?	
	Pnysician: The law requires that the deal this certificate has been signed by the atrail director, page 2 should be detached for	d by	Tarin other significant conditions	contributing to death but	not resulting in the til	derlying cause giv	en in Farti.			☐ Probably 4 ☐ Unknown	
	s been s	lete						24a. Was a	an 24h Wi	ere autopsy findings available	
!	ate has page 2 s	Completed		·				autop perfor	sy pri rmed? de	or to completion of cause of ath?	
'	lan: The		25. Was case referred to medical	<u> </u>			26. Place of Deatl	1 Yes		□Yes 2□No	
	lysician; lis certific director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 ER/Outpatien	t 3 □ DOA Oth	or:		<i>ne)</i> lence 6 □Other	(Specify)	
i	aing Pn h. After thi funeral (	li i	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at		ow injury occurred		
	Attending ir death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		Year) Injury	M 1 🗆	K? Yes 2 □ No				
	al or Atte s after de il Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, farm, stre (Specify)	et, factory, office		28f. Location (S City or Tow	Street and Number In, State)	or Rural Route Number,	
	o the hospital or within 24 hours after To the Funeral Directory filled in the completely filled in the filled in	Medical C	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner state	examination and/or inv	occurred at the tirestigation, in my c	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and man date and place, an	ner as stated. d due to the cause(s)	
- 1	withir To th	M	29b. Signature and title of certifier	- 2		29c. Licens			29d. Date signed (	'Month, Day, Year)	
			S	2 Augingal	_	Doo	515558		A+ - 2:	7-19	
F	20		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, F					- /	
				angat 3	3308 Perr	y St. N	Mount Ra	iner,	MD 2071	2	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar*	s Signature						

Registrar
DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		of Health <i>of Death</i>		-	giene (	9	14944
			1. Decedent's Name (First, Middle, La	ist)	*				2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medi		CARRIE CLIZA	BE th DE	mby				04	2720		5:00 A M
	Examir		4a. Facility Name (If not institution, given	ve street and number)		4b. City, To	wn, or Location	of Death		4c. County		
			Chestertown nurs	ng & REHAL	b. CENTER		STERTO			Xen	7	
	Funeral		5. Social Security Number 6.3	Sex 7. Ag 1 □ M 2 □ 7	e (In yrs. last birthday,	If Under 1	Year If Unde Days Hours	or 24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth	olace (State or Foreign
	Director		220.26.8219	IL M 2027	78 Yrs.				042	31931		TND
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	f eho	5	mo Xent		2 6551 50	1						1 ☐ Yes 2 ☐ No
	the N	ect	10e. Street and Number		Chester	10f. Zip C	ode			10g. Citizen of V	What Cou	ntry?
	with	0		1119		2/				USA		,
	ours after death with the Marylan ral', or Itams 23a or 28e-f ehow Examiner must be modified at	Funeral Director	1/7 5. COI/E9E	12. Was Decedent	Ever in U.S. 13.		nt of Hispanic C Cuban, Mexica	rigin? (Spe	ecify Yes or No		e - Ameri	can Indian,
10	fter c r itan	Ε̈́	1 Never Married 2 Married	Armed Forces?					Rican, etc.)		ck, White,	etc.
93	urs a	þ	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐	No Specify	y:		Specify	3/	9CK
5-0036	72 hours after death with the Maryland natural', or itams 23a or 28e-f show Jical Exa niner met be notified at	Be Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual (	Occupation done during mo	st of work	ina	16b. Kind of Bu	usiness/lr	dustry
2121	within ene.	npie	Elementary/Secondary (0-12)	College (1-4or 5	5+) /ife.	DO NOT use	retired)	, , , , , , , , , , , , , , , , , , , ,	9		/	
21	ed wi	Co	11+4		· D11	nder						TRAJER
pu	be fill H d ott	Be	17. Father's Name (First, Middle, Last	,						Maiden Suman	7	*
yla	ould Men Marke	ဥ	WILLIAM AlbER		ins		CAYI	15 6	LIZAD	exh K. er, City or Town,	215	17
Maryland	l 2 sh and ls m		19a. Informant's Name/Relationship			_						
	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene Important: If item 27 is marked other than "natur any injury or other traumatic event. Its Medical DOCS.		LATOYA FEITON-G.	randdaught	20h Place of Disn	osition (Name	stielde	den	ESTERIO	20c. Location	City or T	20 own State
altimore,	ges It of h		1 Degrial 2 ☐ Cremation 3		cemetery, cre	matory or other	er place)					
ŧ	t. Pa tmer tant:		'4 □Donation 5 □ Other (Speci		DIAnco TAI	th com	munity	5/2/	2009	Chyton	108	est Service
Bal	Depared Impo		21. Signature of Funeral Service Lice	nsee	. (							
			23a. Part. Enter the disease, or con	Carry.	(400026) 8	21000	TREET	FINDA	pous, m	Aryland	2/40	Approximate
			shock, or heart failure. List only	one cause on each li	ne.							Interval Between Onset and Death
	Physician /Medical	H.	Immediate Cause (Final disease or condition resulting in death)	a. aden	ora of R	thur	g wit	in m	retestes	leg		7 month
	Examiner		(	Due to (or as	a consequence of):		0					/
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of):						-	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter fundenting Cause (Disease or injury									
,	exect n and al-tra	Xa	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):							
8760,	ate be executed thysicien and the burial-transit	cai		d								
687	rtificate ng phy as the	100		_ u.						71		
Box	eath certifi attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Da	te of deliv	rery
m	death a atte d for	cla	in the past 12 months? 1 Yes 2 No	4☐Pregnant at		⊒Ectopic preg ⊒ Other (spec				Mo	onth	Day Year
P.O.	the d	hys	9 Unknown	9□ Unknown								
	res that the de signed by the a l be detached f	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in the t	underlying cau	se given in Parl	t I.	23e. Did t	obacco use cont	tribute to	the cause of death?
r S	quire in sig uld b	pe	O CVA with &	Hemipar	esis and	l asp	wation	e on	102	Yes 2□No	3 🗌 Pro	bably 4 □Unknown
8	aw requir as been si 2 should I	oiet	PEG-Tubel	eding		•			24a. Was	an 24b.	Were aut	opsy findings available
Division of Vital Records,	The tav te has age 2	Completed	(3) HTN	7						rmed?	prior to co death? 1 🗌 Yes	ompletion of cause of
ta	sicien: 1 certifical rector, p	0	25. Was case referred to medical				26. Pla	ce of Death	Check only		100	20110
>	ysici is cer direct	OB	examiner?	Hospital:	ent 2 ER/Outpatie	nt 3 DQA	04	1	110-110-11	dence 6 □Oth	er (Speci	fy)
0	ding Phys n. After this funeral di	n: T	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time o	of 280	. Injury at Work?	-		how injury occur		
· jo	ath. rr: Af	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	n	, , , , , , , , , , , , , , , , , , , ,	М	1 ☐ Yes 2 [	□No				
<u>×</u>	for Attendate after death	tifle	3 ☐ Suicide 6 ☐ Could not to determined	286. Place of In	ury - At home, farm, st c. (Specify)	reet, factory, o	office		28f. Location ( City or To	Street and Numb	er or Rur	al Route Number,
	tal or s afte al Dij	Certification:		, , , , , , , , , , , , , , , , , , ,	o. ( <i>Opcony</i> )							
	hour uner uner	cai		hysician: To the best miner: On the basis o								
	To the Hospital or Attending Physicien: The taw requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledicai	one)	and manner sta	ated.							
	To 1 To 1	Σ	29b. Signature and title of certifier				icense number			29d. Date signe	d (Month,	Day, Year)
	B		1/hlhlum	<u> </u>		1	02/3/3	5		4/27/8	19	
	)		30. Name and address of person who	completed cause of d	leath (Item 23a) (Type	Print)	1 1 1					
	2000		KINK. WUN.		hington A	ue, Co	wsterto	un il	nd 216	20		
	Sta		31. Date filed (Month, Day Year)	32. Regis	ar's Signature	hod	1					
	Regist	ar	min &	J COUNTY TEN	ACCOUNT NO.	E 10000	•					

DHMH 17 Rev 1/2001

ORIGINAL

1529 hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Country) Pennsylvania 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No 28a-f show s 23a or 28a-f show e notified at once. PA. Butler Harmony 10g. Citizen of What Country? Direct 10f. Zip Code 10e. Street and Number 16063 S.A 219 South Pittsburgh Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status or items 2 White, etc. Armed Forces? 1 X Never Married 2 Married  $^{2}X$ Yes Specify: White Yes 2 X No specify: hours after Widowed Divorced f Yes. Give Yea the Medical Examiner "natural", ۵ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 27 is marked other than 21215-0036 Education 4 Student nt of Health and Mental Hygiene.

It: If item 27 is marked other the other transatic event, the Medi Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melissa Kennedy Be Charles DiNunzio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) M Street Harmony, PA. 16061 219South Pittsburgh Eric Painter/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition timore, ST.Peters Reformed Church & Cemetery 1X Burial 2 Cremation 3 5-4-09 Zelienople, PA. Department Important: Donation 5 Other Specify 5 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Marzullo Funeral Chapel, P. Road, Baltimore Maryland21214 6009Harford Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause of each line Death /Medical Multiple Injuries Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED attending physician for use as the burial UNPENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) signed by the atte 1 Yes 2 No 9 ✔ Unknown g 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. \$ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has performed. death? Yes 2 1 🗸 Yes 2 Nο certificate 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be Other: examiner? Hospital: Residence 6 V Other: Scene Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 this ို 1 ✓ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Apr 28, 2009 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Certification: Pedestrian struck by auto 1515 hrs 1 Natural Yes 2 V No death. Director: Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc hours after 3 Could not be or Town, State) 16555 Old Emmitsburg Road, Emmitsburg, Md. Suicide (Specify) Local Street 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical within 2 To the F Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 2 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 29, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year,

OCME

**ORIGINAL** 

leneura

104 fla

State

Registra

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2009 14946

		I- For State Registrar	Cer	tificate of	Death		F	Reg. No.	000 1404
Physicia	ın/	Decedent's Name (First, Middle,Last)					Date of Dea     Month	Day Year	3. Time of Death 0805 hrs
ledical Exami			ayah Ligh Forbes		Ott. Tarre	1	April 20, 2	4c. County of	
		4a. Facility Name (if not institution, give Shady Grove Adventist Hos		4	b. City, Town, or Rockville	Location of L	eain	Montgome	
Funeral	7	Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea	ar If Under 2	4Hrs. 8. Date of B	irth (MM/DD/YYYY)	9. Birthplace (State or
Director		220 03 1072	M 2 <b>x</b> F	Yrs.	Months Day		Min. 12/29/		Foreign Country) Maryland
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	on				10d. Inside City Limits
<u>*</u> ,	_	Maryland Prince Ge	orge's		Mit	chell <b>v</b> il	1e		1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			10f, Zip Code			10g. Citizen of Wha	t Country?
th the Maryland 23a or 28a-f sho notified at once		841 St. Michae	el's Drive			20721			U.S.A.
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f Shimatic event, the Medical Examiner must be notified at once	uneral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?				? (Specify Yes or Nuerto Rican, etc.)	o- 14. Race - White,	American Indian, Black, etc.
er deat	F	fundament for the second	1 Yes 2 X No		Yes 2 X No	specify:		Specify:	Caucasian
ırs aftı Iural" Imine	ð	15. Decedent's Education (Specify on	or Dates:	16a. Decedent	t's Usual Occupa	ation (Give kin		16b. Kind of Busi	iness/Industry
72 hou	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	ost of working life	e. DO NOT us	e retired)		
5-0036 led within 72 tygiene. other than '	m d	0			None				None
21215-00 uld be filed wit Mental Hygien marked other c event, the Me	ပ၂	17. Father's Name (First, Middle, Last)				18.Mother's	Name (First, Middle		
212 Jid be Menta marke	o Be	Unknown 19a. Informant's Name/Relationship (T)	/pe, Print )	19b. Mailing	Address (Stre	et and Numbe	er or Rural Route Nu	Ann Forbes umber, City or Town	, State, Zip Code)
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than umatic event, the Medien		Ashley Ann Forbes - N	lother						Maryland 20850
		20a. Method of Disposition	<b>⇒</b> .	Place of Disposi		emetery,	Date	20c. Location - 0	City or Town, State
Pages ment of tant: I or othe		1 X Buriar 2 Cremation 2 4 Donation 3 Other Specify:	removal from State	te of Hea		ery	04/29/2009	Silver S	oring, Maryland
Baltimore, permit. Pages I at Department of Hee Important: If ite		21. Signature of Funeral Service Licens	see	22. N <b>Hi</b>	lame and Addres	s of Facility di Funer	al Home, In	nc.	
		23a. Part Enter the dilea e, or comp	I form that caused the death	11	800 New H	ampshire	Avenue, Si	lver Spring	t Approximate Interval
Physician /Medical		failure. List only one couse on ea	ch line.					.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Between Onset and Death
xaminer			Sudden infant Due to (or as a consequence of		synarome	(21D2			
		Sequentially list conditions, b.							
	ine	cause. Enter Underlying Cause	Due to (or as a consequence of	of):					
B g ig	Examiner		Due to (or as a consequence of	of):		-		·	
760, icate be executed physician and the burial - transit	ical	X UNPENDED	AMENDED 23a,27	perME,	g893 7/	/2/09 T	T	, 1.10	
760, Teate be physici the buri	Medical	IF FEMALE:	23c. If yes, outcome of pres	gnancy				23d. Date of	
ox 687 sath certific		23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of d			Ectopic p	oregnancy	Month	Day Year
Box 68 e death certif the attending	Physician	1 Yes 2 V No 9 Unknown		eath 5 Ot	ther (Specify)				
		Part II. Other significant conditions	contributing to death but not	resulting in the u	underlying cause	given in Part			bute to the cause of death?
ires that the signed by	Completed by						_		Probably 4 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should it	olete							opsy p	Vere autopsy findings available rior to completion of cause of
Reco	E O							1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	eath?  ✓ Yes 2 No
	Be C	25. Was case referred to medical examiner?			26.Plac	1	check only one)		
hysic al dire	10	1 ✓ Yes 2 No		ER/Outpatient			Nursing Home 5	Residence 6	Other:
n of Vital ding Physician: h. After this certif		27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of I	· · ·	jury at Work?		e how injury occurre	eu
Sio of deat ctor	icati	2 Accident Investigation	28e Place of Injury - At I	nome, farm, stre				(Street and Number	er or Rural Route Number, City
Divi	Certification	3 Suicide 6 Could not determined	be	,,	.,,		or Town		
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifying Physici	an: To the best of my knowle	dge, death occur	rred at the time,	date and plac	e, and due to the ca	ause(s) and manner	as stated.
To the Hos within 24 h To the Fun completely	Medical		On the basis of examination and manner stated.	and/or investiga			urred at the time, da		
	ž	29b. Signature and title of certifier				nse number			ed (Month, Day, Year)
		Tamely ou	thall, ms		0.0	C.M.E.		April 22, 20	
		30. Name and address of person who appeared E. Southall, MD	completed cause of death (Itel Assistant Medical Ex		I1 Penn Stre	et, Baltimo	ore, MD 21201		
2	ate					.,			
Regis		31. Date filed (Month, Day Year) MAY 05 20	19 Deneur	J. par	Ked.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 4947 1-Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2310 24 2009 Hurley Foreman April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 11 M 2□ F 30, 83 July 1925 Maryland Director 217-30-8256 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21804 USA Johnson Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1

Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. þ Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer <u>Lumber Mill</u> 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary T. Johnson ျှ William E. Foreman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10601 Worcester Highway, Berlin, Maryland 21811 Virginia Foreman/sister 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Wms Church Cemetery: 05/04/2009 <u>Newark, Marylan d</u> 22. Name and Address of Facility 1213 Jersey Road, Salisbury, M.D. 21. Signature of Funeral Service Licensee JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complication of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cache on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unknown cancer of pancreas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): Physician/Medical

**Physician** 

Baltimore, Maryland 21215-0036

physician

Hospital or Attending Physician: The law requires that the death certificate be executed After filled in by the fo within 24 hours a

þ

Completed

Be

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

		u										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3 🗌	Ectopic Other (						23d. Date of de Month	elivery Day	Year
Part II. Other significant conditio	ns co	ntributing to death but not	resulting in the und	derlying	caus	se given in Part I.		23e. Did	tobacco u	se contribute t	to the caus	e of death?
Bilateral lower e	ext	remity deep	venous th	ron	nbo	sis		1 🗆	Yes 2[	∏No 3∏F	Probably	4∑ Unknown
coronary artery	dis	ease						24a. Was auto perf 1 🗆 Yes	opsy ormed?	prior to death?	completion	lings available n of cause of
25. Was case referred to medical	$\neg \top$					26. Place of De	ath (	Check only	one)	·		
examiner? 1 ☐ Yes 2 ☑ No	Ī	Hospital: 1 🔀 Inpatient :	Othor:					5 ☐ Res	sidence (	6 □Other (Sp	ecify)	
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	28a. Date of Injury (Month, Day, Yea	r) 28b. Time of Injury	М	28c	Injury at Work? 1 □ Yes 2 □ No	28	d. Describe	how injur	y occurred		
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		28e. Place of Injury - A building, etc. (Sp	At home, farm, stree pecify)	et, facto	ory, of	ffice	28		(Street an own, State	d Number or F )	Route	Number,
		rsician: To the best of my iner: On the basis of exar and manner stated.										use(s)
29b. Signature and title of certifier		17 1/1		2	29c. L	icense number			29d. Da	te signed (Mor	ith, Day, Ye	ear)

D30853

Peninsula Regional Medical Center, Salisbury, MD 21801

4/25/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Charles B. Silvia, Jr.

MAY 0.8 2009

31. Date filed (Month, Day, Year)

09-03318 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jennifer Lynn Gray State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle.Last) 2. Date of Death Physician/ Month Day April 25, 2009 1316 hrs **Medical Examiner** Jennifer Lynn Gray 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Waldorf Charles 501 University Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Social Security Number 7. Age (In yrs. last birthday) oreign Months Hours Min Director 550 - 83 - 694926 Feb. 16, 1983 M 2 X F Country)Germany Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 Yes 2 X No Maryland Charles Waldorf death with the Maryland Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 University Drive 20602 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? White, etc. Yes 2 X No White Yes, Give Year Yes 2 X No specify: 3 Widowed Divorced Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Student College ges I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Timothy J. Cope. Sr. Be Sandy L. Bibee 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew L. Gray/ Spouse 501 University Drive, Waldorf, Maryland, 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Pages 1 1 X Burial 2 Cremation 3 crematory or other place) Removal from State partment ( 05/01/2009 Heritage Memorial Waldorf, Maryland Donation 5 Other Specify 5 ignature of Funeral Service Licenses 22. Name and Address of Facility 3035 Old Washington Road Huntt Funeral Home Waldorf, Maryland, 20601 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Seizure disorder Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury maximitiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical 23a,2/,permE, G892 6.3.09 TT Item#5perFH,G894,8/20/09,WS X UNPENDED the attending physician led for use as the burial -AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Fetal death nast 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown 9 Unknown signed by t I be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 V Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural Yes 2 Pending e Funeral Director: letely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

ВB

State Registrar

30. Name and dress of person who completed cause of death (Item 23a) Assistant Medical Examiner

Registrar's Signature

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

**ORIGINAL** 

male

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

MAY U 4 2009

Verthall, MI)

April 26, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1\_ Decedent's Name (First, Middle, Last) Day Year Month Physician 10:37AM 4 2009 OBERT H. GrAVES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner XENT KEMAG. CTR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Chesteetown Mursing 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 100M 2□F 91 214.16.7507 mo Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other then "natural", or Items 23a or 28a-f shov other treumatic event, the Medical Examinat must be collified at 1 Tes 2 No Director Minington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19801 USA 1037 N. MAR STREET death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Tes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. At: If Item 27 is marked other then "natural", or Ite 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: Dlack 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10.70 CITY of Wilmington DE Tublic Wocks 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SADIE STOUTS Unit Graves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any injury or other treu once. PArsha GRAVES DAUg thEL 2109 Wood- Po. 30 23178 Richmond VA 23223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4n.on United methodist 4.21.2009 WORTON Maryland
22. Name and Address of Facility Kenneth Walley Funeral SERVICE \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee (utaa26) 821W. ST. Annapolis, MAryland 21401 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) Carronoma /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Examine burial-transit that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown ATT Commism 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 1 Yes 2 No 2 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death after death.

I Director: After t Certification: 5 Pending investigation 1 ⊆ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical within 24 ho To the Fune completely fi 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Ittle of certifier S 411715 D21J3E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6602 Church hill Rd Chestertown md 21620 Frederick DElbey MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 17 2009

barke

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:05 PM CORNELIA GIVENS 04 2001 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Days 1 □ M 2505 77 218-26-4601 Dec. 16, 1931 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21409 U.S.A. 1618 St. Margaret's Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐Yes 2 X No Specify: 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Tennyson Sarah Cragg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1618 St. Margaret's Road Annapolis, MD James T. Givens/son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4/21/2009 Glen Burnie, Maryland Atlantic Crematory 4 □ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS 3 DAYS Due to (or as a consequence of): 3 DAYS MESENTERIC INFARCTION

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

10a. State

Director

Funeral

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Be Completed

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**Funeral** 

Director

28a-f show ms 23a or 28a-f shorround

I and 2 should be filed within 72 hours after

Pages permit. Pages
Department of
Important: If it
any injury or c

th and Mental Hygiene.
7 is marked other than "natur traumatic event, It a Mexical

other

Baltimore, Maryland 21215-0036

Examiner Be Completed by Physician/Medical Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  c  Due to (or as a consequence of):  d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		pic pregnancy or (specify)		23d. Date of delivery Month Da	
Part II. Other significant conditions	contributing to death but not resulting in the underlyi	ing cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
ACUTE RENAL P	-AILURE		1 □ Yes	2 <b>∑</b> No 3□ Probab	ly 4 ☐ Unknown
			24a. Was an autopsy performed?	prior to comp death?	y findings available letion of cause of
25. Was case referred to medical		26. Place of Death	(Check only one)		
examiner? 1 ☐ Yes 2 🗙 No	Hospital: 1 npatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Hor	me 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work?	28d. Describe how inj		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street and City or Town, Sta	and Number or Rural F te)	Route Number,
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investigand manner stated.	urred at the time, date and place, ation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as sta and place, and due to the	ted. ne cause(s)
29b. Signature and title of certifier	2/	29c. License number	29d. E	Date signed (Month, Da	ay, Year)

State Registrar

within 24 hours a To the Funeral L completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Capstack

31. Date filed (Month, Day, Year)

**APR 21** 

D66753 4/19/09 Medical Parkway, Annapolis MD 21401

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	State of Maryland /	Dan and not of He	acith and Mar	stal Hygiene
	State of Maryland /	Department of De	Ballii anu iviei	ital Hygichic

			- For State			Cert	ificate of	Death				Reg. No.				Time of Dooth
	hysicia		tegistrar 1. Decedent's Name (First,	Middle,Last)					-		1	Date of Dea Month	Day	Year		Time of Death 1937 hrs
٤١.	Exami	ner	Anthony M							May 2, 2009 4c. County of Death						
			4a. Facility Name (if not ins		eet and numb	per)	4	b. City, Towi Hagerst		cation of	Death	Washingt				
			Washington Cour				s. last birthday) If Under 1 Year If Under 24Hrs.					8. Date of Birth (MM/DD/YYYY)				place (State or
	uneral		<ol><li>Social Security Number</li></ol>	6. Sex	7.	Age (In yrs. las	Months Days Hours Min.				_				Foreign	
D	irector		139-94-6887	1 X M	2 F	39						July 29,1969				New Jersey
			Usual Residence of Deced			10c City	Town or Location	on.								10d. Inside City Limits
	a sui		10a. State 10b. C	ounty		Too. Oity,										1 X Yes 2 No
	rand f sho	ō	Maryland Wa	shingto	n		Hager	stown 10f. Zip Co	nde				10g. C	itizen of Wh	at Count	ry?
)	death with the Mayland or items 23a or 28a-f show any must be notified at once.	Director	10e. Street and Number									İ	т.	JSA		
-	3a or		737 Marylar			to the state of th	113 14/0	s Decedent	2174	4U anic Origi	n? (Spe	cify Yes or N			- Americ	an Indian, Black,
	ems 2	Funeral	11. Marital Status  1 Never Married 2		Armed For		If Y	es, specify (	Cuban, N	viexican,	Puerto F	tican, etc.)		White	, etc.	
	or it	Fur		X Divorced of Y		2 X No	1	Yes 2 X	No	specify:				Specify:	W	hite
	rs afte rral", miner	Ď.	3 Widowed 4  15. Decedent's Education	or	Dates:	completed)	16a Deceden	t's Usual Oc	cupation	n (Give k	ind of wo	ork done	.16b	. Kind of Bu	siness/In	dustry
	2 hour	ompleted	Elementary/Secondary		College (1-		during m	ost of working	ng life. L	O NOT	use retire	ea)				
36	hin 7. e. than edica	pldr	12		0		Roc	fer						Roofi	ng C	ompany
00	ygien ygien other he M	Co	17. Father's Name (First,	Middle, Last)					18	3. Mother's	s Name	(First, <b>M</b> iddle	e, Maid	en Surname	)	
215	oe filo ntal H ked e	Be	Lester Gi	adelli				g Address		Mar	gare	t Tors	siel	City or Tow	n State	Zin Code)
21	ould d Mei s mai	2	19a. Informant's Name/Re	lationship (Type	e, Print )											
S	and 2 should be filed within 72 hours affer death with the Madyjano leeth and Mental Hygiene. It was the Madeal Hygiene than "natural", or items 23a or 28a-f she trem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner.		Diana Gira	delli -	- Ex. v	wife	P.O. Place of Dispos	Box	221	Maus etery.	gans	ville. Date	Mc 20	c. Location	- City or	Town, State
ē,	f Heal		20a. Method of Disposition	n emation 3	Removal fro	m State	crematory or of	her place)								
ê	Pages sent o ant: I		4 Donation 5 C	ther Specify:		Ha	gersto	wn Cre	mat	ory	5/8	/09				n, Maryland
alti	permit Pages 1 and 2 should be filed within 72 hours affer posparment of Health and Mental Hygien Fig. Important: If filem 27 is marked other than "natural"; injury or other traumatic event, the <u>Medical Examiner</u> .	1	21. Signature of Funeral	Service License	e			Name and A								
m	E P P		23a. Part I. Enter the disc	E. Vist	~	and the death	4 ]	5 E.	W11s	SON .	BTAG ardiac or	<ul> <li>Hage respiratory</li> </ul>	arrest,	shock, or he	art	Approximate Interval
	ysician		23a. Part I. Enter the dise failure. List only on	ase, or complicate cause on each	ations that ca i line.	iused the death	i, Do not enter	tile mode of	uying, c	,0011 00 0		,				Between Onset and Death
	Medical caminer		Immediate Cause (Final	disease a		oli Sep										
		1	or condition resulting in	ieatti) Du	,	consequence or copenia										
		<u>.</u>	Sequentially list condition if any, leading to immediate		ue to (or as a	consequence of	of):									
		Ę	cause. Enter Underlying (Disease or injury that in	Cause c.		marrow		nction	of	unk	nown	etio	logy	7		
	d sit	Examin	events resulting in death		ue to (or as a	consequence	ום):									
	recute and tran		TY INDENDED	d	AMENDED "	23a,pt.	TT 27 r	or mo	- n20	92 6	_11_	00 wt				
ó	ficate be executed g physician and s the burial - transit	Physician/Medical	X UNPENDED			outcome of pre		- me	go.	72 0	11	OJ VE		23d. Date	of deliver	у
3760,	ificate ig phy s the	2	IF FEMALE: 23b. Was decedent preg	ant in the	1 Live b	irth	2 F	etal death	3	Ectop	ic pregna	ancy		Month		Day Year
Box 68	h certi tendir use a	icia	past 12 months?		4 Pregr	ant at time of d	leath 5 (	Other (Spec	ify)				_	ļ		
Bo	deatl the at ed for	N S	1 Yes 2 No 9	Unknown	9 Unkn		total and the Alexander		201100	iven in F	Part I	23e. [	Did toba	cco use cor	tribute to	the cause of death?
Ö	that the death certifuned by the attending detached for use as	9 P	Part II. Other significan			o geath but not	resulting in the	underlying	caase g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						obably 4 🗸 Unknown
Division of Vital Records. P.O.	ires the signed by the decoration of the decorat		Myocardia	II IIDIC	sis							24a. V	Nas an	24b	. Were a	utopsy findings available
ğ	w requires t as been sign should be	je je											autopsy perform		prior to death?	
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<u>~</u>	un: T ertific	B B						-		of Deatl		only one)			Oth	05
Z.	ysici this c	TO B	examiner? 1 ✓ Yes 2	No Ho		Inpatient 2	ER/Outpatie		OA	, ,		ng Home		esidence 6		61.
ĵ.	After After	D .			28a. Date (Mont	of Injury h, Day,Year)	28b. Time o	of Injury		ry at Wo Yes 2		200. Desc	inde no	W Injury Coo	31.00	
0	tendi eath. for: /	ille il	1 X Natural 5	Pending Investigation	n						- 1-1	29f Local	tion /Str	reet and Nur	nber or F	Rural Route Number, City
. <u>×</u>	or At fler d Direc	ji ji	3 Suicide 6	Could not b	e 28e. Pla	ce of Injury - At	home, farm, st	reet, factory	, onice i	bullaring,	elc.	or To	wn, Sta	ite)		
Ë	pital ours reral	Cortification.	4 Homicide	determined							alana ar	d due to the	cause	(s) and man	ner as st	ated.
	e Hos	etely 5		tifying Physicia	an: To the be On the basis	est of my knowle of examination	edge, death oc n and/or investi	curred at the gation, in my	e time, a y opinioi	n, death	occurred	at the time,	date a	nd place, an	d due to	the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and commendant filled in which funeral director mase 2 should be detached for use as the burial - transitional transitions and the purpose of the properties of the purpose of the properties of the purpose of t	Modical Certification: To Be Con	one) 2 Me		and manner	stated.				se numbe				29d. Date s	igned (N	fonth, Day, Year)
		2	29b. Signature and title	O Certifier	1 1	/				.M.E.				May 3, 2	.009	
				W	.//		02									
			30. Name and address		completed car Chief Med	use of death (It ical Examin	em∠3a) ner 111 F	enn Stre	et, Ba	Itimore	, MD 2	21201				
,			Jack Titus MD  31. Date filed (Month, I			Registra s Sign			41							
		127.7	a si. Date illed (Month, L	uy, roar,	02.		1/4	-	.1 1							

Mr

State St. Date filed (Moritin, Day, Fear)
Registrar

MAY 0 8 2009 Server S.

ers Signature

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Thomas Joseph Hopwood, Jr. April 20, 2009 8:  Examiner  4a. Facility Name (if not institution, give street and number) 210 Bedford Street  Cumberland  5. Social Security Number 220 38 - 2435  1\tilde{M} M 2 F  6. Sex. 7. Age (in yrs. last birthday) 10 Location of Death Yrs. Months Days Hours Min. 08/15/1944  S. Social Security Number 220 38 - 2435  1\tilde{M} M 2 F  6. Sex. 7. Age (in yrs. last birthday) 10 Location of Death Yrs. Months Days Hours Min. 08/15/1944  S. Social Security Number 220 38 - 2435  1\tilde{M} M 2 F  6. Sex. 9. Firthplaces 220 38 - 2435  1\tilde{M} M 2 F  6. Sex. 9. Firthplaces 220 38 - 2435  1\tilde{M} M 2 F  6. Sex. 9. Firthplaces 220 38 - 2435  1\tilde{M} M 2 F  6. Sex. 9. Firthplaces 220 10 Bedford Street  10a. Site	495	2000	ental Hygien		cate of Dea		ryian	State of Ma			1 - For State Registrar	_1	
210 Bedford Street  Cumberland  Allegany  S. Social Security Number  S. Social Security Number  S. Social Security Number  S. Social Security Number  S. Social Security Number  S. Social Security Number  S. Social Security Number  To State   100 Confty   100 City, Town or Location  Town   100 City, Town or Location  Cumberland  Town   100 City, Town or Location  Cumberland  Town   100 City, Town or Location  Town   100 City, Town or	Time of Death : 23 A	ay Year	Month D	Jr.	lopwood,		eph	Jos	lle, Last)				
Description   Description		Allega		erland	Cumbe			reet	d St	Bedfor	210	er	
100. State   100. County   100. Colly, Town or Location   100. If   100. I		9. Birthplac Country 4 Maryl	(Month, Day, Yea					u		435	220-38-2		
11. Marital Status   12 LWas Decedent Ever in U.S. Armed Forces*   12 LWas Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Othan, Merican, Puerlo Rican, etc.)   13 LWas Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Othan, Merican, Puerlo Rican, etc.)   14 LBack, White, etc.   15 LBoodedrit Education   16 LBack, White, etc.   1	nside City Lim	10d		ıd		, Town or Loc	10c. City	7		10b. County	10a. State		
Specify:   Specify:			10g. (	12				reet	d St			al Direc	
Thomas Joseph Hopwood, Sr.   18. Mother's Name (First, Middle, Last)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code)   19. Mailling Address (Street and Number, City or Town, State, Zp code   19. Mailling Address (Street and Number, City or Town, State, Zp code   19. Mailling Address of Facility Address o		Black, White, etc Specify: Whit			es 2⊠No <i>Spe</i>	2 <b>-</b> <sub>1</sub>	° 196	Armed Forces? 1 ☑Yes 2 ☐ N If Yes, Give Year or Dates:	rried	4	1 Never Marri	۵	
Thomas Joseph Hopwood, Sr.   18. Mother's Name (First, Middle, Last)   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, State, Zp Code   19. Mailing Address (Street and Number, City or Town, Stat	•		ng	most of workii	of work done during OT use retired)	(Give I life. E	-)	completed)	nt's Educ est grade	ify only highe	Elementary/Seco	Somplete	
19a. Informants Name/Relationship (Type. Pint)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code   Lori L. Heavner / Daughter   13017 Mill Point Drive, Cumberland, MD 211	lkinso			_		Норwоо		Joseph	, Last)			Be	-
4   Donation   5   Other (Specify)   Cumberland Crematory   04/21/2009   Cumberland,   1   21. Signature of Funeral Service Ucansee   22. Name and Address of Facility Adams   Family Funeral Home   40.4   Decatur Street, Cumberland,   MD   21.5	<sub>e)</sub> 502				•								
21. Signature of Funeral Service Ucansee  22. Name and Address of Facility Adams Family Funeral Home 404 Decatur Street, Cumberland, MD 2150  23a. Pan 1. Ser the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one of the cause of each line.  Arteriosclerotic Cardiovascular Disease  Arteriosclerotic Cardiovascular Disease  Boue to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  d. Due to (or as a consequence of):  d. Due to (or as a consequence of):  d. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Arteriosclerotic Cardiovascular Disease  Due to (or as a consequence of):  d. Due to (or as a consequence of):  d. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Arteriosclerotic Cardiovascular Disease  Due to (or as a consequence of):  d. Due to (or as a consequence of):  Due to (or as a consequence of):  Arteriosclerotic Cardiovascular Disease  Due to (or as a consequence of):  Due to (or as a consequence of):  d. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Arteriosclerotic Cardiovascular Disease  Date of perturbation of the cardiovascular Disease  23d. Date of delivery  Month Day  1   Ves 2   No 3   Probably  24a. Was an autopsy fine of the cardiovascular Disease  24a. Was an autopsy fine of the cardiovascular Disease  24b. Were autopsy fine of the cardiovascular Disease  24c. Was an autopsy fine of the cardiovascular Disease  24c. Was an autopsy fine of the cardiovascular Disease  24c. Was an autopsy fine of the cardiovascular Disease  24c. Was an autopsy fine of the cardiovascular Disease  24c. Was an autopsy fine of the cardiovascular Disease  24c. Was an autopsy fine of the cardiovascular Disease  24c. Was an autopsy fine of the cardiovascular Disease  24c. Was an autopsy fine of the cardiovascular Disease  24c. Was an autopsy fine of the cardiova		•		1				moval from State		Cremation	1 ☐ Burial 2 ]		
Shock, or heart failure. List only one cause on each line.  Interconservation of the construction of the cause of the cause of the cause of the cause. Enter Underlying cause. Enter Underlying that initiated events resulting in death) Last    IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Due to (or as a consequence of):	e, P.A	Funeral Ho	ns Family	Facility Adar	ne and Address of F	22.		am	License	ineral Service	21. Signature of Fu		ouce.
Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate case. Enter Underlying Cause, E	roximate rval Between et and Death	Ir					9.	cause on each lir	r complic t only on	rt failure. List (Final	shock, or hea Immediate Cause ( disease or conditio		
FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day									b. c.	rlying injury	Cause (Disease or that initiated events	Examir	
Metastatic Lung Cancer    1   Yes   2   No   3   Probably	Year	,				déath 3□	2 ☐ Fetal	1 Live birth 4 Pregnant a	23	months?	23b. Was decedent in the past 12 1 □Yes 2 □	nysician/Med	
25. Was case referred to medical examiner?  1 1 1 1 1 No Parameter 2 No No No No No No No No No No No No No				Part I.	ing cause given in F	ting in the un		_				2	
25. Was case referred to medical examiner?  1  Yes 2 No	ion of cause	prior to comp death?	autopsy perform <u>ed</u> ?									Complet	
		6 ☐ Other (Specify)	· · · · · · · · · · · · · · · · · · ·		Other:	R/Outpatient	nt 2 🗆	spital: 1 🗌 Inpatie			examiner?	Be	
building, etc. (Specify)  City or Town, State)	ı <i>te Numb</i> er,	and Number or Rural F	8f. Location (Street	2 □No	1 □Yes	Injury	Year)	(Month, Day 28e. Place of Inju	igation not be	5 ☐ Pendir investi 6 ☐ Could	1 ፟፟∭Natural 2 ☐ Accident 3 ☐ Suicide		
		(s) and manner as stat	and due to the cause			/ledge, death	f my kno	cian: To the best	ng Phys	1□ Certifyii	29a. Certifier		
29a. Certifier (Check only one)  29b. Signature and ille of certifier?  29c. License number  29d. Date signed (Month, Day,						on and/or inv					one)	Medic	
D09157 April 20, 200  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						23a) (Type F	ath (Item	pleted cause of d		ion	MA		

Physician /Medical Examiner

**Physician** /Medical

**Examiner** 

Be Completed by Funeral Director

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Medical Certification: To Be Completed by Physician/Medical Examiner

30. Name a

Name and addr

**Funeral** 

Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

For State Registrar				Certifica	te of	Death			Reg. f	No. 2 1	09	11.95
Decedent's Name (First, Middle								2. Date of Month	1	Day 200	Year	3. Time of Death 13:20PM
ADA JEAN HE Facility Name (If not institution		mher)		4h City	. Town. o	or Location	of Death	APR.	[L 2	2, 200		13.201
FORT WASHINGTO	-					WASHI	NGTO	N		PRINC	E GE	
Social Security Number	6. Sex 1 □ M 2 🙀 F	7. Age (In yrs	s. last birtho Yr	Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth Pay, Year) 1945 TEXAS			
al Residence of Decedent	Λ	0.5						יו דיורי	,	1777		
State 10b. County		10c. C	City, Town o								1	10d. Inside City Limit <b>X</b> □Yes 2□N
D CHAR	RLES			MARBURY	Y ip Code				100	Citizen of W	hat Cour	
Street and Number 1080 ADA PLACE	3			101. 21		0658				NITED		
Marital Status	12. Was Dec	edent Ever in l	U.S.	13. Was Dece	edent of F	Hispanic Or	igin? (Sp	ecify Yes or Rican, etc.)	No-		- Americ	can Indian, etc.
Never Married 2 ☐ Mar	If Yes, G	ive		1 □Yes				. ,		Specify:		ACK
15. Deceden	nt's Education		16a. D	ecedent's Usu	ual Occur	pation			16b.	. Kind of Bus		
	st grade completed) College (		- ' <i>i</i>	Give kind of weighted DO NOT L	use retire	d)	st of work	ing	00	CTAT 4	cpou	TORC
			S	OCIAL V	WUKK		or'e Nam	e (First, Mid		CIAL S		TCEO
Father's Name (First, Middle,	Lasij						AN G		o, maru	Surrame	-/	
. Informant's Name/Relations				Mailing Addres		t and Numb	er or Rui	ral Route Nu			State, Zip	ip Code)
ANA HENSON/DA	MOUIEK		P.	O. DOY	229	, riak	DOVI	, rw 2	OCOU.	•		
METHOD OF DISHOSHION		1 700	Place of F	isnosition /Ma	ame of			Date	200	Location - 1	City or To	own, State
Burial 2 Cremation 4 Donation 5 Other (S	Specify)	State	Place of D cemetery,		CEM	ETERY	4/2	7/2009	NA			IARYLAND
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State Registrar

GUPTA 31. Date filed (Month, Day, Year) APR 2

29b. Signature and title of certifier

ss of person who completed cause of death (Item 23a) (Type, Print) WOODYAR

CLINTON ROAD # 201

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** APRIL 16, 2009 04:00P SONIA ARUSELL HENDRIX /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S CHESTERTOWN 204 RIVER ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5/28/1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min 1 ☐ M 2 🔀 F 89 CA Director 555-20-9517 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, The Madical Examinar must be notified as 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No QUEEN ANNE'S CHESTERTOWN MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 204 RIVER RD. 21620 IISA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces.

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3altimore, Maryland 21215-0020 Š 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM ERIC ARUSELL HANNA SCHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) DR. THOMAS HENDRIX/HUSBAND 204 RIVER RD. CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/20/09 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEÉR RD. CHESTERTOWN, MD 21620 ein 23a. Part1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one carse on each line. Approximate Interval Between Onset and Death **Physician** Cerebral Vascular accident. Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine attending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? ed by the a detached f Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been signed by lirector, page 2 should be detac à 24b. Were autopsy findings available prior to completion of cause of death 24a. Was an autopsy performed? Completed TUYES 231No I or Attending Physician: after death. after death.

Director: After this certification by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Gheck only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home P 2 No 3□ DOA Residence 6 Other (Specify) 1 ☐ Yes 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide 24 hours a Funeral D Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 15 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) ma Mag

Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month, Day,

Year)

APR 20

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 15 Day **Physician** 2009 10:57 PM Lorenda Gertrude Hurley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/04/1935 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □ Days Hours Min. 74 579-48-5326 Washington.D.C. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1218 Cedar Lane 21037 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White "natural", or 1 ☐ Yes 2 No Specify þ 3 XWidowed 4 ☐ Divorced Year or Dates: Be Completed the M dical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Murray Mary Schermerhorn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W. Hurley, III/Son 6341 Porcupine Court, Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 04/21/2009 Washington, D.C. 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur of Funeral Service License 2973 Solomons Island Road, Edgewater, MD 21037 ala Plit1. Enter the disea, or complicit in situations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one is use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis
Due to or as a consequence of): **Physician** /Medical Examiner megacolor TOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed sician and burial-tran Due to (or as a consequence of):  $\mathcal{L} \ \mathcal{M} \ \mathcal{L}$  Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy for Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No ours after death.

eral Director: After this certifice filled in by the funeral director, it Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely

To the I within 2 State

Division or Vital

Maryland 21215-0036

Baltimore,

Registrar

Stephen 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MC 2001 Medical Pkwy Annapolis,

29c. License number

D58510

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03060 State of Maryland / Department of Health and Mental Hygiene Brian R Harris 4 / 27 Certificate of Peath Reg. No #8per FH Amend 2. Date of Death Physician/ Decedent's Name (First, Middle, Last) Month Day April 16, 2009 Year 2051 hrs Medical Examiner Rasheec 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Fort Washington Prince George's Fort Washington Hospital 8. Date of Birth (MM/DD/XYX) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Days Hours Min Months 215-15-3565 Country) Director 25 1 7 M 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10a. State Yes 2 No timore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hours after death with the Maryland timen of Haelth and Meutal Hygiene.

The state of the state MD Director l0g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 304 Aragona Drive 074 Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married Armed Forces? Married Yes Black f Yes, Give Yea 2 No specify: Yes Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ overnmen 17. Father's Name (First, Middle, Last) Linda rvey woodara Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) FORT Washington, MD 20774 Harveu Aragona Drive 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State 1 Burial 2 Cremation 3 Department o *burrechon* Donation 5 Other Specify 22. Name and Address of Facil 2001 21. Signature of Fun Fal Service Licensee -NW , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ximate Interval 23a, Part I. Enter the diseas **Physician** Between Onset and failure. List only one cause on each line. /Mindical Death a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Day Year Month Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? Yes 2 ~ No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital funeral director, Be Other-Hospital: Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred After 1 28b. Time of Injury 27. Manner of Death 28a. Date of Injury Certification; Subject motorcyclist involved in motor vehicle Apr 16, 2009 2008 hrs Natural 1 ✓ Yes 2 No within 24 hours after death. To the Funeral Director: Pending the accident 2 ✓ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 8998 Oxon Hill Road, Fort Washington, MD determined (Specify) Local Street Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier OCME April 17, 2009 OCME 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Assistant Medical Examiner 7 ZÜÜÜ 32. Registrar's 31. Date filed (Month) Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner e RHOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 19 1933 Director 214.30.8149 09 mi Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director WORTOR KENT 28a-f MN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 23a 21678 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 'natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 12 No Specify þ 3 ☐ Widowed 4 ☐ Divorced DIACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) MY Abode LLC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLAYKSTON ဂ္ HOWARD JUNES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau 25549 STILL POND NECK Rd WOLTON, 4ND 21678 JOYCE H. JONES-WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Union United methodist 4.18.2009 WORTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Enneth WATTEY FUNERAL SERVICE 21. Signature of Funeral Service Licens e WOODZEJ 821 W. ST. ANNAPOLIS, MARYLAND 214-01 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** te myelogenous disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit eura Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Cance 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04/14/ 2009 who completed cause of death (Item 23a) (Type, Print)

State Registrar

09-03096 Michael Audury	Jack		ease Type	or Print in Blee of Maryland	ack Ind	lelible	Ink. Er	nsure All C h and Ment	<b>opies Are Le</b> al Hygiene	gible.	
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imore, MD 21215-0036  Pages I and 2 should be fifed within 72 hours after death with the Maryland nnent of Heath and Mental Hygiene.  The man is a marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	T <sub>0</sub>		Name/Relationship a Y. Mart	(Type, Print) tin/Mother		1				umber, City or Town, St ver Spring	T.
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Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Ponation 21. Sign ture of F	5 Other Spec	eify:	Res	surre	ction 2. Name and	Address of Facilit	4/24/2009 Stricklan	d Funeral	
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Division tal or Attendi rs after death.	Certification:	1 Natural 2 Accident	5 Pendin Investig	gation 28e Place of		0301 hr		1 Yes 2 ♥ y, office building, 6	etc. 28f. Location	n (Street and Number o	r Rural Route Number, City
Divisior  Hospital or Attend 24 hours after death Fnneral Director: stely filled in by the	Certif	3 Suicide 4 Homicide		ined (Specify) L						n, State) irk Road, Beltsville, l	
To the Hos within 24 h To the Fm	Medical	29a. Certifier 1 (Check only one) 2	Certifying Phy Medical Exami	iner:On the basis of e	kamination a	ge, death ond/or inves	occurred at th stigation, in m	e time, date and p ny opinion, death o	lace, and due to the ca ccurred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
5	Re								r	29d. Date signed	
		30. Name and ac	dress of person w	HULLEV tho completed cause o	f death (Item	23a)		O.C.M.E.		April 18, 2009	,
EX.		Carol Alla	n, MD Assi	stant Medical Ex	aminer	111 Pe		Baltimore, M	D 21201		
S Regis	tate trar	31. Date filed (M	R 2 7 200	19 Jeneur	trar's Signatu	far.	Ked				

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		-	For State Registrar	State of Mi	ai yianu	-	rtificate of			Reg. No.	2009	11.960
	Physicia	n	Decedent's Name (First, Middle)	e, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	Marion Louise King 4a. Facility Name (If not institution	<del></del>			4b. City, Town, o	r Location of Dea	04	21	0935 м	
	Examin	er	WMHS-Braddock				Cumber		un		County of Death Allegan	у
	Funeral Director		5. Social Security Number 214-07-6536	6. Sex 7. Ag	ge <i>(In yr</i> s. <i>I</i> as <b>92</b>	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	th ly, Year) 1 17, 19	Coui	place (State or Foreign ntry) yland
3	M.		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Maryin 1-f sho	ţo		egany	Fros	stburg						1 X Yes 2 □ No
4 17	here within 7z nous arer bean with the maryland half Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Director		stburg Heights Ap	artments		10f. Zip Code			10g. Citiz	ntry?	
-	sam w	Funeral	Apt  11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	21532-	dispanic Origin? (	Specify Yes or No	U.S.	A. I4. Race - Americ	can Indian.
٥	or iten		1 Never Married 2 Marri	Armed Forces?	•		Was Decedent of H fYes, specify Cub 1 □Yes 2 12 No	an, Mexican, Pue Specify:	rto Rican, etc.)		Black, White,	
5-0036	ural",	d by	3 Widowed 4 □ Divorced	Year or Dates:							Specify: Whi	
ဂ် 🤅	in /z in "nat	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or 5		(Give	dent's Usual Occup kind of work done OO NOT use retire	during most of we	orking	160. KII	nd of Business/In	dustry
7	Hygiene.  Hygiene.  Ither than "  ent, Ire Me	Com	12	0	5+)	home	maker				nemaker	
<u> </u>	in be illi ked oth Ic even	Be	17. Father's Name (First, Middle,  Joseph Francis Ne						ame <i>(First, Middle</i> n <b>Lemmert</b>	, Maiden S	Surname)	
<u> </u>	z should be and Menta Is marked (	၉	19a. Informant's Name/Relations			19b. Mailin	ng Address (Street			er, City or	Town, State, Zij	Code)
Ĕ	ローロー		Arthur King	son			st. Mary's Ave		umberland		Maryland	21502-
ore	permit. Tages 1 and 2 shoud Department of Heath and Mer Important: If Item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition  1 ■ Burial 2 □ Cremation		į		sition (Name of natory or other place	i	Date		cation - City or To	
aitimor	ortant injury		4 Donation 5 Other (S  21. Signature of Funeral Service		S		ick's Cemeter 2. Name and Addre	7	April 24, 2009	Mour	nt Savage M	iaryiand
ñ	Depa Impo any ii		John 1	Calures .	_	:	Durst Fune	ral Home, 5	7 Frost Ave	., Fros	tburg, MD	21532
	1		23a. Puri. Enter the disease, or heart failure. List	complications that caused only one cause on each li	d the death. ine.	Do not ent	er the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	hysician /Medicai		Immediate Cause (Final disease or condition resulting in death)	a. Acute Due to (or as			FAILUR	F			7	We DAYS
	xaminer						RENAL	VASCUL	AR DISE	MSE	0	NE YEAR
7	Sit.	iner										
J, oversided	al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C									
	cia	- 1										
20	aftending physician and for use as the burial-transit	Physician/Medica	IF FEMALE:	1	. —						-10	
XO2	aftend for us	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal d	eath 3	Ectopic pregnand	су		2	23d. Date of deliv Month	ery Day Year
j	by the ached	hysi	1 ☐ Yes 2 ♠No 9 ☐ Unknown	9 Unknown		0						
S, 1	igned be det	by P	Part II. Other significant condition		out not resulti	ng in the ur	nderlying cause giv	en in Part I.				he cause of death?
Sorce	peen s	eted	DEMENTION OF	E ITEMAT FAIR	1405							bably 4 Unknown  bpsy findings available
Vital Records,	te has	Completed	HUPERTEN		- 4/66					psy ormed2	prior to co death?	impletion of cause of
Tal	ertifica ctor, p	Be C	25. Was case referred to medica examiner?						1 ☐ Yes eath (Check only	2 No one)	1 ☐ Yes	2 X No
OT O	this craft dire	ျှ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati	ient 2 El	R/Outpatier	IL 3 LL DOX		Home 5 Res			ify)
SION	ith. : After e funer	tion	1 Natural 5 Pendir 2 Accident investi	ng (Month, Da	ay, Year)	Injury	Wor	ryai k? ]Yes 2 □No	28d. Describe	riow injury	y occurred	
INIS	ter dea frector	Certification:	3 Suicide 6 Could 4 Homicide determ	zinod Zoe. Place of In	jury - At hom tc. (Specify)	e, farm, str	eet, factory, office		28f. Location (	Street and wn, State	d Number or Rur	al Route Number,
בון בון	ours af		200 Cartifier 1 Cartiful	as Physician: To the heat	of my knowl	odao dosti	h occurred at the t	imo data and pla	and due to the	00000000	and manner as	stated
H	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physicompletely filled in by the funeral director, page 2 should be detached for use as the temperature.	Medical		ng Physician: To the best Examiner: On the basis of and manner st	of examination							
Ę	withir comp	Me	29b. Signature and title of certific	1/1-	Δ		29c. Licens	se number	1042	29d. Dat	e signed (Month,	Day, Year)
	4/1			The MILL	U			TI / ( / R/)	IRYLAMI)	AMR	IL XI,	2009
	nas		30. Name and address of person	MOEN M.D.	1068	NAT	PONAL HIG	HWAY	LAVALE	MA	RYLAND	21502
	Sta Registr	te ar	31. Date filed (Mark Do Zar)	1009 Senara	rar's Signatui	par	de l					
						-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylane		tificate of L		Re	g. No. 200	3 14962				
	Physici	an	1. Decedent's Name (First, Middle, La	b. Lilly				2. Date of Death Month Apr. 24	Day Year	3. Time of Death 12:20P M				
and a second	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death					
			National Luth			Rocky			Montgomery					
ı	Funeral Director		-20 /1 0030	6ex 7. Age (In yrs. la. □ M 2\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ADY • / ,	Year) 1926   9. Birthplace (State or Forei Country) Pennsylvani					
	land ow		Usual Residence of Decedent   10a. State											
	e Mary ia-f sh	ctor	Md. Montgo	mery	Roc	ckville			1. Yes 2 No					
	h with the 23a or 28 Int by hal	al Director	10e. Street and Number 9701- Veirs	Drive		10f. Zip Code 2085	50	10	0g. Citizen <i>o</i> f What 0	Country?				
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Nedical Exprising", ust but natified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  \$□  \$□  \$Vidowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  ☐ Yes 2 MNo If Yes, Give Year or Dates:	1	Was Decedent of Hi fYes, specify Cuba I □Yes 2X No		pecify Yes <i>o</i> r No- p Rican, etc.)	14. Race - Ar Black, Wh Specify: W	· ·				
15-(	"natu	Completed	15. Decedent's E (Specify only highest gra	ducation de completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation Juring most of work	ring	16b. Kind of Busines	s/Industry				
212	d withir giene. r than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	/		At Hom	e				
land	ild be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last Leonard	Yeckley			18. Mother's Nam Regi	e (First, Middle, M na Sw	Maiden Surname) itzler					
, Mary	and 2 shousalth and N		19a. Informant's Name/Relationship (	Type. Print) – Son	19b. Mailin				; City or Town, State ⊇rmantoW	, Zip Code) n , Md • 20874				
Baltimore, Maryland 21215-0036	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State	metery, cren ⊇ of	sition (Name of natory or other plac Heaven	Cem 4/2	8/09		pring, Md.				
Balt	permit. Departi Import any Inj once.		21. Signatura of Furreral Service lices	nsee	22 H Y	SONG CO	ss of Facility 2222-	Wiscons	sin Ave.	, NW				
	Physician /Medical Examiner		23a. Part 1. Enter the disease, o cor shock, or heart failure. List ody Immediate Cause (Final disease or condition resulting in death)	plicatir t caused the death. one or use in each line.  a. Due to (or as a construction)	sig	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to (or as a conseque	Due to (or as a consequence of):									
68760,	cate be executed physician and the burial-transit	al Examiner	that initiated events resulting in death) Last	c	ence of):									
O. Box 687	eath certiff attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1	death 3	Ectopic pregnance	4		23d. Date of delivery Month Day Year					
ds, P.	<ul> <li>requires that the d</li> <li>been signed by the</li> <li>should be detached</li> </ul>	by	Part II. Other significant conditions of	23e. Did tot		to the cause of death?								
Recor	: The law req cate has beer page 2 shou	Completed		, , ,		J		24a. Was au autops perforn	y prior t	autopsy findings available o completion of cause of ?				
ta		a)	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 th (Check only on	2 DA10 1 DY	es 2 No				
<u></u>	Physici this cer al direct	8	examiner? 1 ☐ Yes 2 ☐No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3 DOA Othe			ence 6 ☐ Other (S	pecify)				
מים	ding Pt h. After tr funeral	ion:	27. Manner of Dath  1 Natural 5 ☐ Pending	(Month, Day, Year)	28b. Time of Injury	Work		28d. Describe ho	ow injury occurred					
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, to	Certification: To	Accident investigatio  3 ☐ Suicide 6 ☐ Could not b  4 ☐ Homicide determined	e 28e Place of Injury - At hon	ne, farm, stre		Yes 2□No	28f. Location (St City or Town	n (Street and Number or Rural Route Number, Town, State)					
_	ause(s) and manner ate and place, and c	as stated. ue to the cause(s)												
	To the To the Comple	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens			9d. Date signed (Mo					
	5		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) 9701 1	leirs Di	ire Roc	4/24/0	20810				
	Sta Registr	te	31. Date filed (Month, Day, Year) APR 2 7 2009	32. Registrar's Signatu				,						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 4963 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Rov Elwood Mooney, Sr. April 25. 2009 7:12 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Allegany Co. Nursing and Rehab Ctr. Cumberland If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 10/6/1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 17 M 2□F 83 Ohio Director 298-12-6118 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show item 27 is marked other than "netural", or items 23a or 28e-f shov other traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD LaVale Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 940 Oaklawn Avenue 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Tire and Rubber Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Ernest Mooney Ruth Et.hel Leake ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norma L. Mooney / Wife 940 Oaklawn Avenue, LaVale, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 04/28/2009 Cumberland, MD `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Sinn yur ol Funeral Servige Lice 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Pnysician Obolnich 16VV5 resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ Accident 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No of or Attending Physicien: after death. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 \ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title ofcertifier 29c. License number DOU 33280 Anvie 25, 2009 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nas. Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD 32. Registrar's Signature Day, Year) 31. Date liled (Month State 2009 Registrar

09-03245 Douglas McClure

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		Re	For State gistrar	_		tificate o			ai i iygi <del>c</del> iic	Reg. I	No.	
Physical Exar		•	Decedent's Name (First, M Douglas J. Me						2. Date of Month	of Death Da 22, 200	ay Year	3. Time of Death 2145 hrs
Tical Exal				ution, give street and number	)		4b. City, Town,	or Location of		22, 200	4c. County of Deat	
and the second			4288 Eastern Neck				Rock Hall				Kent	
Funera Directo			Social Security Number 221–30–0111	1X M 2 F	ge (In yrs. I	ast birthday) Yrs		ear If Under ays Hours	Min	of Birth(N	Forei	rthplace (State or ign ountry) DE
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits		
Aaryland 28a-f show	ar once.	5		Castle	Wil	mingtor						1 Yes 2 XNo
e Mary	Director	10	e. Street and Number	am d D d			10f. Zip Code			10g.	Citizen of What Cou	untry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho			2306 Faulkla	12. Was Deceder				Hispanic Origi	in? ( Specify Yes			rican Indian, Black,
death or item	Europral	1	Never Married 2	1X Yes 2	? ! No	lf Y			Puerto Rican, et	c.)	White, etc.	
rs after ural",		3		Divorced If Yas, Give Year or Dates: 1 9 Specify only highest grade co	67-71	16a Deceder	Yes 2X		ind of work done	16	Specify: Wh:	
72 hou	ompleted		Elementary/Secondary (0-				nost of working I				,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
within jene.	Medic		12	4		Truc	k Drive		(=:		Transport	tation
21215-0036 and be filed within 7 Mental Hygiene. marked other than	or other traumatic event, the Medical	)   ''	7. Father's Name (First, Mid Paul McHugh	dle, Last)					s Name (First, Mi lie Bucl	·	den Sumame)	
212 nould b	2   G		a. Informant's Name/Relation	onship (Type, Print )		19b. Mailin	g Address (St				r, City or Town, Stat	e, Zip Code)
, MC and 2 si ealth ar	E Lan		Nancy McClure  Da. Method of Disposition	e/ Wife	20b.		Fau1k1		l. Wilmin		n, DE 1980	
Baltimore, MD Permit. Pages I and 2 sh Department of Health and Important: If item 27 is	orner	1	Burial 2 X Crema	ition 3 Removal from S	tate	crematory or of	ther place)				,	·
altin mit. P. partmen	injury or	21	Donation 5 Other . Signature of Funeral Serv	r Specify: vice Licensee	но	22.	Cremat	ess of Facility	4/27/200	79   F	Hockessin	, DE
		00	Kick of	, or complications that cause	$\supseteq$	13	30 Speen	Rd. C	hestert	own,	m Funera MD 21620	Approximate later of
Physicia /Medica		L	failure. List only one car	use on each line.				ig, such as ca	irdiac or respirato	ory arrest,	snock, or near	Approximate Interval Between Onset and Death
Examine	er		nmediate Cause (Final disea condition resulting in death	400 4.			sease					
	à		equentially list conditions, any, leading to immediate	b Due to (or as a cons	sequence o	f):						-
	Evamine	ea (D	luse. Enter Underlying Cau Disease or injury that initiate	ed c.								
ruted	Tansır F		vents resulting in death) La	dd.	sequence o	i).						
760, cate be executed physician and	Modical	200	UNPENDED	AMENDED				•				
8760, ifficate be	n / Ma		FEMALE: b. Was decedent pregnant i	23c. If yes, outco	me of preg		etal death	3 Ectopic	pregnancy		23d. Date of delive Month	ry Day Year
Box 687 e death certific	or use as u	[]   1   1	past 12 months?  Yes 2 No 9	4 Pregnant a	t time of	- =	ther (Specify)			_		·
D. B.		`L		ditions contributing to dea	th but not r	esulting in the	underlying caus	e given in Par	rt I. 23e.	Did tobac	cco use contribute to	the cause of death?
, P.O		2	Diabetes Mellitus						1	Yes 2	2 No 3 Pro	obably 4 Unknown
Records, The law requir	Completed	ומומ							24a.	Was an autopsy	prior to	utopsy findings available completion of cause of
tal Rec	Bage 7								1	performe Yes 2 ✓		res 2 No
'ital sician: is certi	a a	25	b. Was case referred to med examiner?	Hospital:	ent 2	ER/Outpatien		Other	Check only one)  Nursing Home	5 Res	sidence 6 🗸 Othe	er: Scene
of Vitaling Physician: After this certi	E F	27	1 Yes 2 No  Nanner of Death	28a. Date of In (Month, Day)	ury	28b. Time of	1	njury at Work?		-	injury occurred	-
Sion ttendii death.	y me n	5 1 2 2		Pending nvestigation				Yes 2				
Division is or Attendir as after death.	Tilled in by the rune	3		Could not be letermined (Specify)	njury - At h	ome, farm, stre	et, factory, offic	e building, etc		ation (Stre own, State		tural Route Number, City
e e pi	<u>ج</u> ا د	29	Homicide  Pa. Certifier  Certifying	g Physician: To the best of r	ny knowled	ge, death occu	rred at the time	date and place	ce, and due to th	e cause(s	) and manner as sta	ited.
Fo the within 2	Modical	on	2 Medical E	Examiner: On the basis of examiner stated	amination a	nd/or investiga			curred at the time			
	<b>1</b>	29	b. Signature and title of cer	rtifier				ense number			9d. Date signed <i>(M</i> April 23, 2009	onth, Day, Year)
12		30. Name and address of person who completed cause of death (Item 23a)										
m( +		30	Laron Locke MD.	Assistant Medical Ex	,	•	n Street, Ba	timore, MI	O 21201			
	Stat	_	. Date filed (Month, Day, Ye	2 8 2009 32. Regi	ars Signati	ire	Sach					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:03а м Anne Frances Moeller April 22, 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 🗓 F 68 218-38-5571 February 12, 1941 DC Usual Residence of Decedent 10a. State 10d. Inside City Limits 10h. County 10c. City, Town or Location 1 ☐ Yes 2 No Charlotte Punta Gorda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2600 Rio Tiber Drive 33950 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2XXNo White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) High School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Paul Wheatley Frances Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl E. Moeller / Husband 2600 Rio Tiber Drive, Punta Gorda, FL 33950 20b. Place of Disposition (Name of cemetery, crematory or other place Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, VA April 23, 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL disease or condition resulting in death) Due to (or as a consequence of): THEROSCLEROTIC HYPER TENSION Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

**Physician** /Medical Examiner

physician a s the burial-t

attending pl

signed by the a

certificate has been s rector, page 2 should

director

After this

after death Director: filled in by the

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completely

2

Completed

Be

Certification: To

Medical

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evers was must be a sufficed at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

<u>۾</u>

Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy perform 2 No

1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗆 No

1∐ Yes 2 🕦 27. Manner of Death

2 Accident

4 Homicide

3 Suicide

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

🗹 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number MD56845 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EEN 31. Date filed (Month, Day, Year)

7610 CARLOU AVE

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EIROSE M /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 3914 BELLE OF GEORGIA ANE ASADENA Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months. Days Hours Min. Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience, ast the restitled at 10b County PASADEN 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number death with 2ハスス U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{Vo} \) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MITCHELL DLINE PATTON ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3914 RELIE OF GEORGIA-AVE. ASALENAMD - Z1122Date 20c. Location - City or Town, State nt of Health a t: If item 27 is y or other trai Sharon EDDY, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Department of Important: If any injury or once. -4-09 ELKRIDGE, MD. 4 ☐ Donation 5 ☐ Other (Specify) DAUGHERTY FUNERAL HOME Signature of Funeral Service Licensee 2601 MOUNTAINED PASADENA, M.D. ZIIZZ 23a. Part1. Enter the disease, or complication that caused the shock, or heart failure. List only the cause on each line Approximate Interval Between Onset and Death at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Myocardia Physician disease or condition resulting in death) /Medical Due to (or consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Dav 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 □Yes 2 No 2 🗆 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes Hospital: Other: 4 \sum Nursing Home 2 □ No 5 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 2 Accident s after death. 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ひこょみもら MD address of person who completed cause of death (Item 23a) (Type, Print) 2106 1 Road WD 7845 Munesca 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar ranko DHMH 17 Rev 1/2001

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tem 4a per phys. G881.578709 dk. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 30, 2009 1:30 p<sup>M</sup> m April <u>Brian Christopher Moorehead</u> /Medical la. Facility Name (If not institution, give streat and number)
21209 Queen's Rock Lane
Russell-R.--Moorehead 4b. City, Town, or Location of Death 4c. County of Death **Examiner** A<u>llegany</u> Moorehead McCoole If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/21/67 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 236-13-3246 Yrs. 41 WV Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinat must be notified at MD Allegany McCoole 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21209 Queen's Rock Lane 21562 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes ∰∏No If Yes, Give Year or Dates: M Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed)  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Maintenance College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell R. Moorehead Beverly Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beverly Carder mother 21213 Queen's Rock Lane, McCoole, MD 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Potomac Memorial 5/04/09 4 Donation 5 □Other (Specify) Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 22. Name and Address of Facility Approximate Interval Between Onset and Death CARCINOMA METASTATIC & SOPHAGEAL Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical MAY 200, Due to (or as a consequence of): **Examiner** Eague, fielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Division of Vital e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 Z No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 904 Seton Drive Cumberland, MD 21502 Zaman Wamar 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

376

Registrar

MAY 0.8 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Gary Kermit Nesselrodt April 25, 2009 2121 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WMHS-Memorial Campus Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 63 219-44-2279 Director 02/21/1946 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, the Medical Exprired must be required an once. 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Allegany Cumberland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12518 Goldens Avenue, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ▼ No Specify: Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Paper Laborer 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Lonnie Kermit Nesselrodt Leona Kathryn Berg ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Nesselrodt / Wife 12518 Goldens Avenue, SE, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 04/29/2009 Cumberland, MD 21. Signat re f Funeral Service Lice 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Arterioscleratic Heart Disease
Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed bunial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, aftending physician for use as the buna Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Be Completed Border Line Diabetes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2□No 1 □ Yes 2 **∑** 1 ☐ Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) မ

50/10

State Registrar

DHMH 17 Rev 1/2001

124 West Third Street, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Snow,

Paul

D09157

April 26, 2009

21502

09-03308 Lee Nauven

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

9

ee Nguyen		1- For State											
Physiciar	n/	Registrar  1. Decedent's Name (First, Midd	lle,Last)					2	. Date of Dea	***	- 0.0	3. Time of Death	
Medical Examin			Le Van Ngu						Month April 24, 2	1009	ear	1711 hrs	
		4a. Facility Name (if not institution Laurel Regional Hosp		nber)		b. City, Town, or Laurel	· Location of	f Death		4c. County Prince			
Funeral		5. Social Security Number	100	7. Age (In yrs.	last birthday)	If Under 1 Year Months Day		24Hrs.	8. Date of Bir	th(MM/DD/YYY	Y) 9. Birti Foreigi	hplace (State or	
Director	ļ	046-86-7866	1 M 2 F	7	1 Yrs	World's Day	3 110013	IVIII.	May 1	2, 1937		untry) Vietnam	
япу	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Locati	on				-		10d. Inside City Limits	
<u> </u>	اڃ	Maryland Princ	e George's			I.	aurel					1 Yes 2 No	
daryla	Director	10e. Street and Number	000180 0			10f. Zip Code	duter		1	0g. Citizen of W	/hat Coun	itry?	
h the l		15301 Laure	ton Drive				20707	7			U.	S.A.	
death with the Maryland or items 23a or 28a-f sho	Funeral	11. Marital Status  1 Never Married 2 X M		edent Ever in U rces?		s Decedent of His es, specify Cubar					e - Amerio	can Indian, Black,	
ler de			1 Yes	2 <b>X</b> No	1	Yes 2 X No	specify:			Specify:	As	sian	
hours at "natural Examin	<u>6</u>	15. Decedent's Education (Spe	or Dates:	e completed)	16a. Deceden	t's Usual Occupa	tion (Give k			16b. Kind of B			
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21215-0036 Unid be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Unascertainable	, 2000					,		vialden Sumam	6)		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23 or 28a-f she marked other than "natural", or items 23 or 28a-f she are event, the Medical Examiner must be notified at once		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Stree		certainable nber or Rural Route Number, City or Town, State, Zip Code)					
무무분모동	ŀ	Thoa Thi Nguyen  20a. Method of Disposition	- Wife	20h		1 Laurelto			urel, Ma	aryland 2		Town State	
Baltimore, MD 2 shoul began I bages I and 2 shoul bepartment of Health and M mportant: If item 27 is migury or other traumatic.	1	1 X Burial 2 Crematio	n 3 Removal fro	m State	crematory or oth	er place)					,		
Baltimore permit. Pages 1 Department of F Important: IG	ŀ	4 Donation 5 Other S 21. Sign sture of Funeral Service		Ga	22. N	ven Cemete ame and Address	s of Facility		2/2009		Sprin	g, Maryland	
	11800 New Hampshire								nue.Sil	lver Spri	ng. Ma	arvland 20904	
Physician /Medical		23a. Part I, Enter the direate, or failure. List only ned use	on each line.							est, shock, or h	eart	Approximate Interval Between Onset and	
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68760, certificate be executed nding physician and se as the burial - transit	<u> </u>	Xunpended	d. X AMENDED	#1 as r	noted, 2	3a,27,p	erME,	g891	5/20	/09 TT			
de buri	Ned-	IF FEMALE:	23c. If yes, or	utcome of pred	inancy					23d. Date of	of delivery	,	
30x 6876 death certificat e attending phy I for use as the	2	3b. Was decedent pregnant in the past 12 months?	1 Live bir		2 Fet	al death 3	Ectopic	pregnanc	:y	Month	•	Day Year	
	3	1 Yes 2 No 9 Un	known g Unknow		5 Oth	er (Specify)							
P.O.	2	Part II. Other significant condi	ions contributing to	death but not r	esulting in the u	nderlying cause (	given in Par	t I.				the cause of death?	
S, P.C. Unives that the signed I lid be deta	ב ב	<u>-                                      </u>	<u>.</u>		-							ably 4 Unknown	
of Vital Records, ng Physician: The law requires ther this certificate has been signeral director, page 2 should be not To Re Compileted.	2								24a. Was			topsy findings available completion of cause of	
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ttendi death.		1 X Natural 5 Pend 2 Accident Inve		ouy, rour)		1,	Yes 2 1	No					
Division o spital or Attending hours after death.  neral Director: After filled in by the fune Certification:		. dete	d not be rmined (Specify)	of Injury - At h	ome, farm, stree	t, factory, office b	uilding, etc.	. 28	or Town, S		ber or Rur	ral Route Number, City	
Hospit Hospit Funers ely fills		29a. Certifier	nysician: To the best	of my knowled	ne death occurr	ed at the time da	ate and plac	e and du	ie to the caus	e(s) and manne	ar ac etate	ad	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attention of the funeral director. The page 2 should be detached for Medical Certification: To Re Compiletely filled in by the funeral director. To Re Compiletely the Division Medical Certification: To Re Compiletely by Division Research and Province			miner:On the basis of and manner sta	examination a									
		29b. Signature and title of certifie				29c. Licens		0000	_			nth, Day, Year)	
	L	Theodore Ul.	King JR	, m	. ).	0.C.	M.E.	OCME	:	April 25, 2	.009		
	3	<ol> <li>Name and address of person Theodore M. King, Jr.</li> </ol>		of death (Item It Medical E	,	111 Penn Sti	reet, Balt	imore	MD 21201				
State	e 3	81. Date filed (Month, Day Year)		istrar's Signat	<b>8</b> 0 <b>0</b>								
Registra		GU YAM	LUUS Ckne	and B	park	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 913 CHRISTINE DELORES PLETZER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** tos Dita 101 nemoria Year | If Under 24 Hrs. 5. Social Security Number If Under 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 👿 F Months Days Hours Min. 75 Director 220-28-1112 OCT. 12, 1933 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Mudical Examiner must be notified at 1 □Yes 2 🙀 No Director WYE MILLS MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 14150 OLD WYE MILLS ROAD 21679 USA 23a Funeral , or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ▼ Married Baltimore, Maryland 21215-0036 ≥ If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify: WHITE Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "1 Elementary/Secondary (0-12) College (1-4or 5+) PRINTING PRINTING PRESS OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be REUBEN FRANKLIN JAMAR J. LOUISE USILTON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If Item 27 i any Injury or other tra once. GEORGE A. PLETZER/HUSBAND 14150 OLD WYE MILLS ROAD, WYE MILLS, MD 21679 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION STEVENSVILLE, MD 4-28-2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final Ald Vasc **Physician** 1) < disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). law requires that the death certificate be executed Exami attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 100

9 Unknown-Month Year Dav 5 ☐ Other (specify) P.O. | ed by the a s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 2 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 The perforn certificate 1 ☐Yes 2 ☐ No Division of Vital 1 Yes /2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred or Attending 1 Natural 2 ☐ Accident 5 Pending investigation Vithin 24 hours after occ...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number μ 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 00

State Registrar 31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygienes on o

Division of Vital Records, P.O. Box 68760,	Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician; The law requires that the death certificate be executed $\mathbf{W} > \mathbf{P}$	
Within 24 Hours arief dearn.	Department of Health and Mental Hygiene.
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

			1 - State Registrar	, , , , , , , , , , , , , , , ,	Certific	cate of L	Death		Reg. No.	US	1 4	911
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Day	Year	3. Time o	
- 14	/Medic		FRANCES CARTER	PYLE				APRIL	22 200	9	1:3	0 P M
,	Examin	er	4a. Facility Name (If not institution, glv	_			Location of Death		4c. County		1 a	
	Funeral		5. Social Security Number 6. S	· · · · · · · · · · · · · · · · · · ·		CENTRE\	If Under 24 Hrs.	8. Date of Birt	QUEEN		ace (State	or Foreian
	Funeral Director			□ M 2 <b>X</b> F <b>79</b>	Yrs. Mon	ths Days	Hours Min.	(Month, Da	y, Year) <b>8,</b> 1929	Count	(TLAND	
	land ow		10a. State 10b. County	10c. City	, Town or Location					10	d. Inside C	City Limits
	Mary a-f sh	żo	MD QUEEN A	NNE'S	CHESTER						1 ☐ Yes	2 <b>X</b> No
	or 28	Director	10e. Street and Number		10f	. Zip Code			10g. Citizen of W	hat Count	ry?	
	23a cret b	ral	2603 HARRINGTON	ROAD		2161	19		USA			
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "refical Evan	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  ☐Yes 2 No If Yes, Give Year or Dates:		77	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE			
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	Jucation de completed)	16a. Decedent's	Usual Occupa	ation Juring most of worki	na	16b. Kind of Bu	siness/Ind	ustry	
121	/ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEM	OT use retired,	)		OWN H	OMT?		
7	filed v Hygie ther t		11 17. Father's Name (First, Middle, Last,		понц	AKEK	18. Mother's Name	(First Middle				
ylan	should be filed within nd Mental Hygiene. marked other than Imatic event, Inc. Matic	To Be	FRANCIS BENNETT				MARGARE			,		
Jar	2 should to and Men Is marked raumatic		19a. Informant's Name/Relationship (	**	1		and Number or Rura		-	State, Zip	Code)	
e,	t and Health		EDGAR L. PYLE II		·		OURT, CHE	ESTER, N	<b>1D</b> 21619 20c. Location - 0	Pity or To	un Stata	
altimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important; If Item 27 Is any injury or other tra		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification)	Removal from State STE	lace of Disposition emetery, crematory	or other place  E CEME	TERY APRII 200	i9 <sup>26</sup>	STEVENS	VILLE	, MD	
Ba	perm Depa Impo any ii		21. Signature of Furier Service Licer	A C	FELL 106	ÖWS, H SHAMRO	ELFENBEIN CK ROAD,	& NEWN CHESTER	NAM FUNE R, MD 210	RAL H	OME,	P.A.
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not enter the	mode of dying	g, such as cardiac	or respiratory a	rrest,		Approxima Interval Be	etween
4.	Physician		Immediate Cause (Final disease or condition	RESPIRATORY	Failure						Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):							
		7	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ence of):					-		
	uted	Examiner	Cause (Disease or injury	bao to (or ac a consequ	101100 01).							
Ć,	exection and and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):							
68760,	icate be executed physician and the burial-transit	ical		d								
89	ertifica ing pt as th	Medical	IF FEMALE:		-	Ti.						
.O. Bo	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome of pregnar  1	death 3 Ector	pic pregnancy r <i>(sp</i> ec <i>ify)</i>			23d. Date Mor	of delive	-	Year
ν, σ.	iires that signed t		Part II. Other significant conditions of	ontributing to death but not resu	Iting in the underlyi	ng cause give	n in Part I.	23e. Did to	obacco use contr	bute to the	e cause of	death?
ž	w require s been sig should b	ed b	MS					1 🗆 1	∕es 2□No	3 ☐ Proba	ably 4	10nknown
Vital Records,	sician; The law re certificate has be irector, page 2 sho	Completed by						24a. Was autop perfo 1 🗆 Yes	rmed?   d	/ere autoprior to coneath?	sy findings	available cause of
Vita	ician; sertific ector,	Be (	25. Was case referred to medical examiner?			- 11-6	26. Place of Death			antar	OTAM	IIID
o	Physical direction	٦.	1 Yes 2 No 27, Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3   28b. Time of		4 🗆 Nursing Ho				CENT	EK
Division of	ding h. After funer	tion	1 Matural 5 ☐ Pending	(Month, Day, Year)	Injury M	28c. Injury Work	rat ? ∕es 2 □No	28a. Describe r	now injury occurre	a		
/ISI	Atten r deat sctor: by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	me, farm, street, fac			28f. Location (5	Street and Numbe	r or Rural	Route Nur	nber,
	tal or Attendii s after death. al Director: A ed in by the fu	Certification: To	4 Homicide determined	building, etc. (Specify	")			City or Tov	vn, State)			
,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical (	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exar	nysician: To the best of my knowniner: On the basis of examinat and manner stated.	wiedge, death occu ion and/or investiga	rred at the timation, in my op	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s) and ma date and place, a	nner as st nd due to	ated. the cause(	s)
	Vithi To th	ž	29b. Signature and title of certifier			29c. License			29d. Date signed	(Month, L	Day, Year)	
				Juim my	,	06374	17		4/23/	09		
				completed cause of death (Item	23a) (Type, Print)	11. 0		1 00				
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure	The HON	, consent	u 14 2	1617			
	Sta Registra		APRZ	completed cause of death (Item  32. Registrar's Signate	A. 600	Best						

			1 - For State Registrar	01410 01 141	arylana / D		tificate (				Reg. No.		17714
			1. Decedent's Name (First, Middle	Last)				_		2. Date of Dea	th		3. Time of Death
	Physici /Medi		Gale	Lvr	ın		Re	eeves		Month April	26.	y Year 2009	1945 <sup>M</sup>
No. of Street,	Examir		4a. Facility Name (If not institution,	give street and number,	)		4b. City, Tow	n, or Locatio	n of Death			County of Deat	
-1			WMHS-Braddoo	k Campus				Cumber:	land			Alle	gany
	Funeral			6. Sex 7. Ag	ge (In yrs. last birtf	iday)	If Under 1 Ye	ear If Und	er 24 Hrs. Min.	8. Date of Birtl (Month, Day	Year)	9 Birt	hplace (State or Foreign untry)
и	Director		220-84-2164	1□M 2∏ F	47 Y	rs.	WOTTE	ayo moun	14111.	08/31/1	961		yland
	put 💉		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	orloa	enting						40d India City Limits
	sho	5	Tod. State Tob. County		Toc. City, Town	OI LOU	ation						10d. Inside City Limits 1 □ Yes 2 □ No
	he M	Director	MD Alle	gany		umb	perland						21
	with t				204		10f. Zip Cod		20		10g. Citi	izen of What Co	untry?
	s 23	Funeral		reet, Apt 2		40.14	( 5 )	2150		7 77		USA	
	item	F	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decedent Armed Forces?	?	IS. V	Yes, specify (	of Hispanic ( Cuban, Mexic	origin? (Spec can, Puerto F	cify Yes or No- Rican, etc.)		<ol> <li>Race - Amer Black, White</li> </ol>	
336	Irs af	þ	3 V Widowed 4 □ Divorced	ed 1 ∏Yes 2 √ If Yes, Give A Year or Dates:	140	1	□Yes 2√	No Speci	fy:			Specify:	
Ģ	be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Eversiaes", or the mortified at	Completed	15. Decedent's	Education	16a. I	Deced	ent's Usual O	ccupation			16b. Ki	W nd of Business/I	hite ndustrv
215	nin 7; an "n	ble	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or s		Give k life. D	ind of work do O NOT use re	one during m etired)	ost of workin	g			,
2	d with gience	Ö	12	2	5+)		Homema	aker				Home	
p	e file al Hy othe vent,	Be (	17. Father's Name (First, Middle, L	ast)				18. Mo	ther's Name	(First, Middle,	Maiden	Surname)	
<u>a</u>	uld b Ment Irked tric e	၉	John	Henry	Gane	ge		Eli	zabeth		Mar	У	Vincent
ar	2 should I and Men is marke	1 3	19a. Informant's Name/Relationsh	p (Type. Print)	19b.	Mailing	Address (Str	reet and Nun	nber or Rural	Route Numbe	r, City o	r Town, State, Z	ip Code)
Σ.	and 2 ealth n 27 i		Gale L. VanHoute	n / Daughte	er	Ρ.	.0. box	413,	Wiley	Ford,	WV	26767	
ore	of Heritan		20a. Method of Disposition		20b. Place of I cemetery	Dispos	ition (Name o atory or other	f place)	Da	ate	20c. Lo	cation - City or	Town, State
Ĕ	Pages nent of ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		1			i	San O4	/30/200	a T	Flintsto	one MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventuse to use the multiple at once.		21. Signature of Funeral Service L	censee	1	22.	Name and A	ddress of Fac	ility Adai	ms Fami	ly l	Funeral	Home, P.A.
<b>n</b>	20 E 2 2		Mille	uagun-	J	4	04 Dec	atur S	Street	, Cumbe	rlaı	nd, MD	21502
			23a. Part 1. Error the disease, or c shock, or heart fallure. List o	omplications that cause	d the death. Do no	t ente	r the mode of	dying, such	as cardiac or	respiratory arr	est,		Approximate Interval Between
1 No. 10.	Physician		Immediate Cause (Finel disease or condition	Hemort									Onset and Death
	/Medical		resulting in death)	<b>-</b>	a consequence of	):							
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	ש פ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that in the cause)		a consequence of	):							
	ecute ind trans	ami	triat iritiated events	c End St	age Chro	nic	Obstr	uctive	e Airwa	ay Dise	ase		
Š,	e exisian a	ũ	resulting in death) Last		a consequence of	):							
<b>68/60</b>	certificate be executed nding physician and ise as the burial-transit	Medical		d. Anemia									
٥	± 5.6	Mec	IF FEMALE:										
ô	death cer le attendir id for use	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □	Ectopic pregn	nancy			2	23d. Date of deli	•
_ 	the a	Physician/	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 🗌	Other (specif)	y)				Month	Day Year
Σ.	d by letacl	F.		a contribution to double b			de de de conse			on- Distri			the course of death 0
Š,	res the signe pe d	ğ	Part II. Other significant condition Anxiety	s contributing to death b	out not resulting in t	ne uno	eriying cause	given in Par	τι.				the cause of death?
ecoras,	requi	Completed							<u></u>	1 1 1 1	es 2L	_No 3∐Pro	obably 4 Unknown
ec C	e law has b e 2 sl	ם	Clostridium Di	fficle asso	ociated o	lise	ease			24a. Was a		24b. Were aut	topsy findings available ompletion of cause of
=	: The	S								perform 1 ☐ Yes		death? 1 □ Yes	2 🗆 No
VITal	lcian Sertifi ector	Be	25. Was case referred to medical examiner?						ce of Death	(Check only on	e)		
5	this all dir	၉	1 ☐ Yes 2 ☑ No		ent 2 ER/Outp		O DOY		Nursing Hom	e 5 🗆 Reside	ence 6	6 ☐ Other (Spec	ify)
Sion of	ling I	Certification:	27. Manner of Death 1   ↑ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ıry 28b. Tir ıy, Yea <i>r)</i> Inji	ne of ury		njury at Work?		Bd. Describe ho	ow injury	y occurred	
<u>S</u>	ttend death ttor: the	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t he				1 □Yes 2[					
2	or A after Direction by	rtif	4 ☐ Homicide determin	ed 28e. Place of injusting, et	ury - At home, farn c. <i>(Specify)</i>	ı, stree	et, factory, offi	ce	28	31. Location (Si City or Town	treet and n, State)	d Number or Ru )	ral Route Number,
_	pital ours eral filled		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge	dosth	000118504 -1 11	o time -1-1	and place	ad du- t- "			-1-1-1
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	(Check only 2 Medical E.	Physician: To the best caminer: On the basis o and manner sta	of examination and/	or inve	estigation, in r	ny opinion, d	eath occurre	d at the time, d	ause(s) ate and	place, and due	to the cause(s)
	ompl.	Me	29b. Signature and title of certifier	and manner sta			29c. Lic	ense numbe	r	2	9d, Date	e signed (Month	, Day, Year)
			M.9.0	0_	Mn			D00660				il 27,	
	2	ŀ	20 Name and address of pares	no completed source of a	loath (Itom 33a) (T	mo P						;	
	71 65		30. Name and address of pelson w Madhusudhan					n Driv	e. Cum	berlan	d. M	ID 2150	2
	Sta	te	31. Date filed (Month. Day. Year)	2 32 Registra	ar's Signature				- ,		-, -,		
	Registra		APR 28 2009	Deneura 1	9. park								
		204		1				-					

traumatic event, the Medical Examinar must be notified at Director 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "x-order any injury or other traumation." or items \$ Completed Be ပ **Physician** /Medical Examiner Examiner the burial-tran attending physician Box 68760 or Attending Physician: The law requires that the death certificate be Physician/Medical P.O. Division of Vital Records. Completed by Be Certification: To After this To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A þ Medical 3/2 MRS State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** 2:10 A Verta Reed April 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Village Montgomery Village Care and Rehab Montgomery | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 1 / 18 / 19 15 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 27 F Months Maryland 218-16-3966 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 21 No MD Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20874 USA 19220 Mateny Hill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 State Government Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eliza Brown Thomas Jenkins, Sr. Susan Joseph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell Householder / Grandson 19220 Mateny Hill Road, Germantown, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Savage UMC Cem. 04/25/2009 Mt. Savage, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Mensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Emili the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 🗀 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number H0051280 April 21, 2009 30. Name and address of per without the way of death (Item 23a) (Type, Print) 10110 Molecular Dr., Rockville, Maryland 20850 Anushiravan Dadgar, M.D., 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month PRIL Day 24, Year 219 **Physician** 10:00FM Hilda Marie Randolph /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** owson Joseph Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 😿 F Director 87 October 21 1921 Maryland 578-28-3575 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examinar mass has resisted. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1¥2 Yes 2 ☐ No Directo Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1024 Bramly\_Drive 21742 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: à 3 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Samue1 I. Cochran Nettie Lizier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1024 Bramly Dr. Hagerstown Maryland 21742 Lloyd E. Randolph / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/1/2009 Hagerstown Maryland Rest Haven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.M 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician COMPLETE HEART BLOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions Examiner ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation eral Director: A 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 19236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 OSLER DRIVE, STEPHEN H. M. D. . 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DY C

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Shober 20, 2009 Norma Lee 3:45 A M April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Golden Living Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 217 F 80 213-24-5982 Director 05/24/1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State a or 28a-f show the notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 210 Allendale Avenue 21502 ral", or Items 23a of Examiner must b Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify. Specify 2 White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abram Chisholm 0cea Odella Cessna ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Carol Brunner / Daughter 10708 Oak Forest Drive, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 등 permit. Page Department o Important: If any injury or once, Restlawn Mem. Gardens 04/23/2009 LaVale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. ldars 404 Decatur Street, Cumberland, MD Part I. F. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician rulm onary 4168085 ears /Medical Due to (or as a consequence of): Examiner thrive 3monta ailure to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner 3 mortly burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Rheumatoid azthritis 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate has 2**30**No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 47 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Itama Scrawl M B) 4120109 D46346 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huma Shakil, M.D., 625 Kent Avenue, Cumberland, MD n de 21502

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1:26 P M Virginia Schade 1.00 2009 April 23, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Golden Living Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 212 F 90 08/05/1918 214-05-7960 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 TyYes 2 □ No Director Allegany Cumber land 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 10 N. Liberty Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Samuel Binnix Gertrude Caroline Sowers ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3875 S. Swartz Road, Bloomington, IN Larry A. Rinker / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/27/2009 Sunset Memorial Park Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Rome, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADENO CARCINOMA Physician Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to for as a consequence off Examiner requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the l aftending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð MENTI 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N. lens rain 00064167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUE CUMBERLAND MEMORIAL ANI nos 500 82. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 18, Day 2009 Year 5:52 P M ROBERT FRAME SIEMEN 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death KENT CHESTERTOWN HERON POINT 8. Date of Birth 11/29/1921 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 1**X** M 2 □ F Days Hours Min. PA 221-14-1450 87 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No DE SUSSEX DEWEY BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1706 BAYARD AVE 19971 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married WWII If Yes, Give Year or Dates: 1 □Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 EMPLOYMENT SUPERVISOR CHEMICAL 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ARTHUR CLEVELAND SIEMEN IRENE TRUITT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1706 BAYARD AVE DEWEY BEACH, FLORENCE L. SIEMEN/WIFE DE 19971 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DE VETERANS CEMETERY 4/22/09 BEAR, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the pa Immediate Cause (Final 2= CANCED disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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event, the Medical

27 Is marked or traumatic ev

item 27 other t

permit. Pages 1
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Important: If ite
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Director

Funeral

Completed by

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

burial-trar

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

attending physician for use as the buria signed by the a certificate funeral director, After this death. al or Attendi s after death. I Director: A filled in by the

Physician/Medical ≥ Completed Be

Certification: To To the Hospital o within 24 hours af To the Funeral Di completely filled in

25. Was case referred to medical 2 Accident 3 ☐ Suicide

1 ☐ Yes 26. Place of Death (Check only one) 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Were autopsy findings available prior to completion of cause of death? 2 No

1 ☐ Yes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

and manner stated

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b Time of

28c. Injury at Work? 1 ☐ Yes

2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signatu

4 ☐ Homicide

29a. Certifier

0060301

31. Date filed (Month, Day, Year)

cause of death, (Item 23a), (Type, Print)

M NS (3a) Shewn Ru SPES

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State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of Death	Re 2. Date of Deatl	eg. No.2009	3. Time of	378
	Physici /Medi		BARBARA JEANNE SPEAKER		APRIL	23 2009		<b>A</b> M
-	Examir		4a. Facility Name (If not institution, give street and number)  1001 CHESAPEAKE DRIVE	4b. City, Town, or Location of Death STEVENSVILLE		4c. County of Dea		
j	Funeral Director		5. Social Security Number  577-44-9443  6. Sex 1 □ M 2 ▼ F  7. Age (In yrs. last birtho	fay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, JULY 8,	9. Bit 1935 WAS	thplace (State of ountry) HINGTON,	
	e Maryland 3a-f show	ctor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town o				10d. Inside Cit	
	with th	I Director	10e. Street and Number  1813 SOUTH EAST 14TH STREET	10f. Zip Code <b>33904</b>	10	0g. Citizen of What C	•	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Expirit har roughly any once.	by Funeral		13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	erican Indian, e, etc.	
21215-0036	ithin 72 hou ne. han "natura e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of worki fe. DO NOT use retired)	ng	16b. Kind of Business		
Maryland 21	d be filed wantal Hygie ed other ti event, th	Be	12 17. Father's Name (First, Middle, Last) UNKNOWN	SECRETARY  18. Mother's Name BERNICE		ELECTRIC  Maiden Surname)	COMPANY	. ,
aryl	should and Me smark umatic	P P		ailing Address (Street and Number or Rura		City or Town, State,	Zip Code)	
e, ⊠	1 and 2 Health sm 27 is			D1 BENTON'S PLEASURE				
Baltimore,	it. Pages rtment of I rtant: If ite njury or of		1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CARE CREMATION APRIL CENTER 200	924	STEVENSVIL	LE, MD	
Ba	Depa Impo any I		21. Signature of Funeral Service Litensee	FELLOWS, HELFENBEIN 106 SHAMROCK ROAD,	& NEWNA	AM FUNERAL	HOME, P	P.A.
Ę,	Physician /Medical		23a. Part T. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a.		or respiratory arre		Approximate Interval Betw Onset and D	veen
	Examiner	Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury		0			
68760,	ficate be executed physician and s the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C					
.O. Box 68	ath certi Ittending or use a	Physician/Med		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month		ear
ords, P.	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tob	acco use contribute t s 2 ☐ No 3 ☐ P	o the cause of de	
Vital Records,	sıclan: The law r certificate has be irector, page 2 sh	Completed			24a. Was an autopsy perform 1 □ Yes 2	prior to death?	utopsy findings a completion of ca s 2 □ No	vailable suse of
<b>=</b>	lysicial	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	26. Place of Death		DAUG nce 6 DAUG	HTER'S	
Division of	Io the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director; t	Certification: To	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident investigation	e of 28c. Injury at 27cry M 1 Yes 2 No		w injury occurred	34,5211011	
	pital or At ours after d eral Direct filled in by		4 Homicide determined building, etc. (Specify)		City or Town,			oer,
	ne Hos in 24 ho he Fun pletely	edical	29a. Certifier  (Check only one)  Check only one)  rtifying Physician: To the best of my knowledge, do not the basis of examination and/o and manner stated.	eath occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)	
	Voithi Comp	Ž	29b. Signature and title of certifier  Mechi Ci. Hantrer t	29c. License number  M		9d. Date signed (Monitory) 4-24-	th, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type Mic King Archive) in the second secon	De, Print)				
	Sta Registra	e l	31. Date filed (Month, Day, Year)  32. Registrar's Signature  APR 24 2009  Leave A.	barke				
			THE IN A COULD PARTY OF					

			1 – For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of a		and Mental H	ygiene Reg. No. 2	2009	14979		
	Dharis		1. Decedent's Name (First, Middle, Las	t)				2. Date of I	Death Day	Year	3. Time of Death		
0	Physici /Medio		MARY LEONA	SMITH				APRIL	21	2009	7:30 PM		
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location o	of Death	4c. C	County of Death			
de Carlo			1712 MAIN STREET				/ENSVI			QUEEN A			
ı	Funeral Director		218-16-8327	9X 7. Age □ M 2 <b>X</b> F	e (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	Hours	Min. (Month,	7, 192	Cou	place (State or Foreign ntry) XYLAND		
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits		
	Mary f sh	ţ	MARYLAND QUEEN	ANNE'S			CTEVE	NSVILLE			1 □Yes 2 <b>X</b> ]No		
	the 28a	Director	10e. Street and Number	ANNL D		10f. Zip Code	DIEVE	MDAIDE	10g. Citize	en of What Cou	ntry?		
	3a ol	<u>=</u>	1712 MAIN STREET			21	666		IIN	ITED ST	ATES		
	death ms 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S. 13.			gin? (Specify Yes or I , Puerto Rican, etc.)		4. Race - Amer	ican Indian,		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Medical Evarinar must be notified at	<b>₽</b>	1 ☐ Never Married 2 ☐ Married 3 😿 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates:	No l	n Yes, specily Cuba 1 ∐Yes 2 <b>T</b> No	Specify:	, Puerto Rican, etc.)		Black, White, etc.  Specify: WHITE			
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occup	ation	t of warking	16b. Kind	16b. Kind of Business/Industry			
2	within 7 iene. than "i	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life.	OO NOT use retired	d)	or working	FO	FOOD SERVICE			
2	filed wi Hygier Sther th	ပွဲ	11		CAP	AFETERIA WORKER FOOD SERVICE  18. Mother's Name (First, Middle, Maiden Surname)							
pu	be file	Be	17. Father's Name (First, Middle, Last)						,	,			
yla	should and Men Men marke	၉	THOMAS CLARK					AMELIA CLI					
Maryland	2 sho hand risma rauma		19a. Informant's Name/Relationship (7					er or Rural Route Nun					
	1 and 2 Health em 27 i		CINDY TAYLOR/DAT	JGHTEK	20b. Place of Dispo		KOAD,	CHESTER, N		ND Z161 ation - City or T			
Baltimore,	Page nent c ant: If ury or		1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	cemetery, crer	natory or other plac	reky	APRIL 25, 2009			E, MARYLAND			
Ball	permit. Pag Department Important: I any injury o once.		21. Sign wire of turn of envice/Lice.	Hell	BEIN AND I			L HOME, P.A. 21619					
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or companies shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a	a consequence of:	YOCC	lo vl	cardiac or respiratory	arrest,	J.	Approximate Interval Between Onset and Death		
8760,	cate be executed physician and the burial-transit	I Examine	Sequentially list conditions, if on, leading land cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of):								
87	cate physi the b	dical		.d									
O. Box 6	ath certifi ttending   or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	; <b>у</b>		23	very Day Year			
rds, P.	uires that the de n signed by the a ild be detached f	d by Ph	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the u	nderlying cause giv	en in Part I.			se contribute to	the cause of death?		
I Records,	The law requir ate has been s page 2 should l	Completed by						24a. W. au pe 1 🗆 Yes	topsy rformed?	prior to death?	opsy findings available ompletion of cause of		
Vital	stan: srtifica stor, p	Be C	25. Was case referred to medical examiner?				26. Place	of Death (Check onl					
f V	hysic his ce I direc		examiner? 1 ☐ Yes 2 ☐ o		ent 2 ER/Outpatier	nt 3□DOA Oth	ier: 4 🗆 Nu	rsing Home 5K Re	esidence 6	☐Other (Spec	ify)		
Division of	nding Plath. r: After the	ation:	27. Manner of Death  ▼ atural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	y, Year) 28b. Time o	Wor	ryat k?  Yes 2□		e how injury	occurred			
Divis	al or Attend s after death, al Director: A	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubuilding, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location City or 1	(Street and own, State)	Number or Ru	ral Route Number,		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner sta	of my knowledge, deat f examination and/or in ated.	h occurred at the ti vestigation, in my o	me, date ar opinion, dea	nd place, and due to t ath occurred at the tim	he cause(s) ne, date and	and manner as place, and due	stated. to the cause(s)		
	To the within comp	M	29b. Signature and title ocertifier	mu	>	29c. Licens	3 J d	36	29d. Date	signed (Month	, Day, Year)		
			30. Name and address of person (who	completed cause of d	eath (Item 23a) (Type,	1	00	4619					
<b>19</b> ,	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	the M							
DH	MH 17 Rev 1/2		APR 2	2009 Ch	was B.	Barker							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:45 pM Mary Gilliam Smith April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Days Hours Min Director 218-56-6292 94 January 12, 1915 Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shor 1 ☐ Yes 2K No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 15008 Donna Drive 20905 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ≥ Specify: Specify. 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Menta item 27 is marked r other traumatic e James Skelton Gilliam 2 Virginia Ruffin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta S. Wilhelm - Daughter 2379 Kays Mill Road, Finksburg, Maryland 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 04/24/2009 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. -(11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Causedisease or condition resulting in death) - Imal **Physician** Cardiopulmonary Arrest /Medical Due to (or as a consequence of): Examiner Respiratory Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit and Hyperkalemia Due to (or as a consequence of): Box 68760 physician The law requires that the death certificate be Physician/Medical Hyponatrimia the attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ď in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🛂 No signed by the a o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate of Vital 1 □ Yes 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ġ 1 ☐ Yes 2 🛣 No 1 X Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this s after death.

I Director: After this of in by the funeral d Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending Injury investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral filled 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifi 29c. License number ျ 29d. Date signed (Month, Day, Year) D55861 April 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul Munim, M.D., 8379 Cherry Lane, Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. Pegistrar's Signatur State 24 Registrar

DHMH 17 Rev 1/2001

09-03347 Richard Smith

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

14981 2009

Chara Office		- For State Certific	cate of Death	Reg. N	lo	
Physicia	ın/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death 1112 hrs
ler" ¬I Exami		Richard E. Smith	At C'ty Taylor and agetion of Dog	Month Da April 26, 2009	4c. County of Death	
		4a. Facility Name (if not institution, give street and number) 1023 East Baltimore Street	4b. City, Town, or Location of Dea Baltimore		40. County or Dout	· _
Euroral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last b		rs. 8. Date of Birth (N	M/DD/YYYY) 9. Bir	thplace (State or Foreign
Funeral Director		434-59-2629 <sub>1</sub> X <sub>M 2</sub> F 2	2 3 Yrs. Months Days Hours M	Aug.26		ouisiana
· •		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow	vn or Location			10d. Inside City Limits
Maryland 28a-f show a		Maryland Balti	imore			1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	0 L	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cou	intry?
he Ma	Öire	524 South Bethel Street	21231	U	.S.A.	
with 1 ms 23 ms 23 ms	ā	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Amer White, etc.	rican Indian, Black,
death wi	Funeral	1 XNever Married 2 Married Armed Forces? 1 Yes 2X No		10 14,00.1, 0,0.1,		it.
after	by	Widowed 4 Divorced If Yes, Give Yeer or Dates:	1 Yes 2X No specify:  a. Decedent's Usual Occupation (Give kind of	of work done	Specify: W I  b. Kind of Business	nite /Industry
hours		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	during most of working life. DO NOT use r		D. Tana di Edomode	
36 Jin 72 Ihan dical	흺	, , ,	Laborer	(	Construc	ction
215-0036 be filed within 7 atal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid	den Surname)	
215 be file ntal H rked o	Be	Ray L. Smith, Sr.	Cynth  19b. Mailing Address (Street and Number of	ia Herri	ck	
Dre, MD 21215-0036 so I and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 is marked other than "natural", her trammatic event, the Medical Examiner	မ					
MD and 2 sho alth and m 27 is		Ray L. Smith, Sr./Father	1421 Bienville B	LVD., Mob	<u>lle, Alab</u>	oama 36608 or Town, State
ore, selar of Hez						
imc Page ment o		4 Donation 5 Other Specify: Main	natory or other place)  Street Cemetery  22 Name and Address of Facility	5-3-09	Kowiey, M	assaciiuse
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility M	larzullo:	Funeral	rCharal 12
		23a. Part I. Enter the disease, or complications that caused the death. Do	6009Hartord Ro	c or respiratory arrest,	shock, or heart	Approximate Interval
Physician Wedical		failure. List only one cause on each line.				Between Onset and Death
∡aminer		Immediate Cause (Final disease or condition resulting in death)  Difference Cardio  Due to (or as a consequence of):	omyopathy			
		Sequentially list conditions, b.				
	ner	if any, leading to immediate Due to (or as a consequence of):				-,-
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
outed nd rransit		ď	001 5 (11 /00 m			
60, ate be executed obysician and re burial - transi	ledical	X UNPENDED 23a,2/,p	erME, g891 5/11/09 T	Т		
	≥	IF FEMALE: 23c. If yes, outcome of pregnar	0 5-1-1		23d. Date of delive	
68 Griff Ging	hysician	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death	2 Fetal death 3 Ectopic pre  5 Other (Specify)	gnancy	Month	Day Year
Box e death c the atten ed for us	ysic	1 Yes 2 No 9 Unknown g Unknown	5 Other (Specify)			
O. E at the deby the etached	Δ.	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.			to the cause of death?
, P.	d by			_		robably 4 Unknown
Records: The law requificate has been a page 2 should	Completed			24a. Was an autopsy	prior t	autopsy findings available completion of cause of
BCO ne law te has	ᄩ			perform 1 ✓ Yes 2		
	ပိ	25. Was case referred to medical	26.Place of Death (Ch	eck only one)		
ion of Vital I tending Physician: leath. for: After this certif the funeral director,	) M	examiner?  1 Vers 2 No  Hospital: 1 Inpatient 2 El	R/Outpatient 3 DOA Other; No	Temis trains	esidence 6 🗸 Ot	her: Scene
1 of V ding Ph.	=	27. Manner of Death 28a. Date of Injury (Month Day Year)	8b. Time of Injury 28c. Injury at Work?	1	w injury occurred	
	[흝	1 X Natural 5 Pending	1Yes 2No			
Division tal or Attendii rs after death al Director: A	<u>ii</u>	3 Suicide 6 Could not be 28e. Place of Injury - At hom	ne, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		Rural Route Number, City
Division  To the Hospital or Attention 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined (Specify)		)) <u> </u>		
Dio the Hospital vithin 24 hours to the Funeral ompletely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge. (Check only 1 Medical Examiner: On the basis of examination and	e, death occurred at the time, date and place,	and due to the cause ed at the time, date ar	(s) and manner as s nd place, and due to	tated. the cause(s)
To the within To the comple	Medical	and manner stated.	29c. License number		29d. Date signed (	
	2	29b. Signature/and title of certifier	O.C.M.E.	1	April 27, 2009	
		U Christen W			, , , , , , , , , , , , , , , , , , , ,	
		30. Name and address of person who completed cause of death (Item 2: Laron Locke MD. Assistant Medical Examiner	3a) 111 Penn Street, Baltimore, MD 2	21201		
		31. Date filed (Month, Day, Year)  32. Regist ar's Signature				
Regis			A. park			

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year **Physician** Month Edith Marv 25. 5:00 A Tetlow April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Co. Nursing & Rehab Ctr. Allegany Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F 85 Director 579-18-6520 05/13/1923 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or itema 23a or 28e-f show the Modical Examiner must be notified at 1 Yes 2 No Elkridge MD Howard Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code USA 6692 Aspern Drive 21075 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental Heet: If item 27 is marked ott and Mental Charles Fornwald Harris Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Tetlow / Husband 6692 Aspern Drive, Elkridge, MD 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö I ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) lle Vet. Cem 104/30/2009 Crownsville, MD 22. Name and Address of Facility Adams Family Funeral Home, Crownsville Vet. Cem | 04/30/2009 21. Signature of Funeral Service Creensee 21502 404 Decatur Street, Cumberland, MD Part1. Her the diseas , or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Bilaler **Physician** neumona 1 milh /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ed by the atter detached for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown line Completed been 24b. Were autopsy findings available prior to completion of cause of death? this certificete has autopsy performed? 2∏ No 2 No 1 Tes 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation M after death 2 Accident illed in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funaral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 29c. License number 1)0033200 HOVIL 25 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nose M.D., 625 Kent Avenue, Cumberland, MD Gupta, Sunil K. 31. Date filed (Month, Day, Year) APR 29 32. Aegistrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar
DHMH 17 Rev 1/2001

Amended #23a(b), nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per phy., 04/21/09, State of Maryland / Department of Health and Mental Hygiene Allegany Co. Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2198 M /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner REHAB AND NURSING AKLAWD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Hours Months Davs 1**™** M 2□ F 60 November 29, 1948 Maryland 217-54-7043 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location show ir than "natural", or items 23a or 28a-f showing the Wedical Examiner must be notified at 1 □Yes 2 No Director Frostburg Maryland Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17109 Mount Savage Road, N.W. U.S.A. 21532-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cemetery grounds keeper 12 2 should be filed w h and Mental Hygie 'Is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iva E. Rosenberger Albert R. Via ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a Maryland 21502-20 Richard Way LaVale Albert N. Via brother injury or other Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If ite Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State April 20, 2009 Finzel 4 ☐ Donation 5 ☐ Other (Specify) **Emmanuel Methodist Cemetery** 22. Name and Address of Facility 21. Signature of Funeral Service Licens Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 16 olu Approximate Interval Between Onset and Death 23a. B. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory minute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Probable Arteriosclerotic Coronary Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed ng physician and as the burial-transi Due to (or as a consequence of) Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No Ö 9 Unknown ď 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MORBIS 0 Bes1 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No Marral 1 □ Yes of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed caus

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month U 4 331 **Physician** 00 7+ 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Upper Marlboro 14611 Mt. Calvert Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) New York Days Hours Months 1 M 2 F 039-07-8498 92 9/23/1916 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 ☐ Yes 2 No Director Maryland | Prince George Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14611 Mt. Calvert Road 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖔 No Specify Specify: White ð 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sears, Roebuck&Co. Interior Design 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Wilson Ralph L. Beck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Matthew James Bronstein/Nephew 3115 Westover Dr. S.E. Washington, DC 20020 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Kalas Crematory 4/19/2009 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home Funeral Service Ligenses de 6160 Oxon Hill Rd. Oxon Hill, MD. 20745 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caty on each line. Immediate Cause (Final Physician End lein disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. <u>会</u> 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en performe 1 ☐Yes 2 ZNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records,

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Merdail Hyglene. Internative if Health and Merdail Hyglene "natural", or items 23a or 28a-f show Important: If then 27 la marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, he reading Exercises must be notified at

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attending physician

Baltimore, Maryland 21215-0036

e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifice completely filled in by the To the within 2 State Registrar

Medical

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of pertific

29c. License number

Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person will completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 2 1 2009

6 ☐ Could not be

3 Suicide

29a, Certifier

4 Homicide

(Check only

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	ate of Maryland		rtment of H		Mental Hygie Reg.	-20119	14986
	Physici	an	Decedent's Name (First, Middle, Last)	ack WALD				2. Date of Death Month	Day Year	3. Time of Death
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	Examin	er 	Washington Adventist	Hospital		Takoma	Park		Montgom	ery
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 M	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 31.	ar) C	thplace (State or Foreign ountry) nnsylvania
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	ation		10411. 013	1310   10	10d. Inside City Limits
	th the Marylan or 28a-f show	ctor	Maryland Montgomery			Spring				1 □ Yes 2 <b>X</b> □ No
	ath with the Maryla 23a or 28a-f sho	Funeral Director	10e. Street and Number 2900 N. Leisure Worl	d Blvd., #20	1	10f. Zip Code 209	06		citizen of What Co	,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminar must be mailled anone.	by Funer	1 Never Married 2 Married 1	/as Decedent Ever in U.S. rmed Forces ☐Yes 2 ☐No Yes, Give ear or Dates:	if	/as Decedent of Hi Yes, specify Cubar □Yes 2 1 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.
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Maryland 21215-0036	uld be file Mental Hy irked othe	To Be (	17. Father's Name (First, Middle, Last)	oseph I. Wal	d			ne <i>(Fir</i> st, <i>Middle, Maid</i> Se Frank	den Surname)	
Mar	d 2 sho th and 7 is ma trauma	. 4	19a. Informant's Name/Relationship <i>(Type. F</i> Shirley Cohen Wald, W							zip Code) 20906 r Spring, MD
Je,	of Heal		20a. Method of Disposition	20b. Place		ition (Name of atory or other place			Location - City or	
Baltimore,	t. Page rtment rtant: II		1 N Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	al from State	David	Memoria	Garden	04/26/09		Church, VA
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q	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	of):	3	USEGN			years
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al Re	sician: The law certificate has rector, page 2 s	Compl	reale rengi tal	iare				24a. Was an autopsy performed 1 □ Yes 2	prior to death?	utopsy findings available completion of cause of s 2 \(\simegarrow\) No
VIII.	nysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospit	al: Malinpatient 2 ☐ ER/	Outnation	3 DOA Othe	r.	th <i>(Check only one)</i> Iome 5 ☐ Residence	e DOthor (Co.	
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Division of Vital Records,	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Certification: To	2 Accident investigation	e. Place of Injury - At home, building, etc. <i>(Specify)</i>	, farm, stre		′es 2 □No	28f. Location (Stree City or Town, S	t and Number or R tate)	tural Route Number,
_	Hospital 4 hours Tuneral ely filled	ical Ce	(Check only 2 Medical Examiner:	n: To the best of my knowled On the basis of examination	dge, death	occurred at the timestigation, in my or	ne, date and place	e, and due to the caus	e(s) and manner a	as stated. e to the cause(s)
	Fo the 1 Within 2 Fo the 1	Medical	one) 29b. Signature and title of certifier	nd manner stated.		29c. License			Date signed (Mon	
	5		1 Deductor	Cepus		83	6601	F	tpril 2	3,2009
_			30. Name and address of person who comple  DAVID M. BRIL	led cause of death (Item 23: L, M, N 790 33 Registrar's Signature	a) (Type, P ) / W	aple Av	re., Tak	oma Par	rkmb 2	20912
	` Sta	_	31. Date filed (Month, Day, Year)  APR 24 2009	33 Registrar's Signature	par	Ked				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 JOHN NELSON WHITE 5:05A MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7879 WICKER LANE LA PLATA CHARLES 6 Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1**X** M 2 □ F Director 59 217-60-8504 JAN.19,1950 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Expension in ust be putfilled at once. 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location MD CHARLES 1 ☐ Yes XIXNo Director LA PLATA 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 7879 WICKER LANE 20646 S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Armed Forces?
1 ★Yes 2 No
If Yes, Give 171 - 176
Year or Dates: 71 - 176 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DRIVER SALESMAN CENTER DIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLARENCE WHITE MARTHA BISHOFF MITCHELL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA L. WHITE / 7879 WICKER LANE LA PLATA, MD 20646 WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State METRO CREMATORY MAY 5,2009 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licensee M00641 5635 WASHINGTON AVE. LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician anco 6 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as 1 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 □Yes 2-25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 2 | 3 | 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal (Check only one) and manner stated. the within ? To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 0 0 31. Date filed (Month, Day, Registrar's Signature Year) State Registrar

DK

DHMH 17 Rev 1/2001

09-03286 David A. Wolford	, Sr.	Please Type or Print in Black Indelible by Ensure All Copi State of Maryland / Department of Health and Mental H	<b>es Are Legi</b> l lygiene	ble. 2009 14988
Physicia	F	- For State Registrar 1. Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death	No. 3. Time of Death
Medical Examir	ner	DAVID ALAN WOLFORD  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deat	April 24, 200	4c. County of Death
	Ц	Memorial Hospital  Cumberland  5. Social Security Number	rs 8 Date of Birth/	Allegany  MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		215–90–7701 1XM 2 F 47 Yrs. Months Days Hours Mi	_	Foreign
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36 thin 72 h than "r edical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 MECHANIC	·	AUTOMOBILE
15-0036 filed within 7 I Hygiene. ed other than t, the Medica		The same of the sa	ne (First, Middle, Ma	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Thien 27 is marked other than "natural", or other traumatic event, the Medical Examines.	To Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of	r Rural Route Numb	er, City or Town, State, Zip Code)
P, MD and 2 sho lealth and tem 27 is		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City or Town, State
Baltimore, Department of Her Important: If ite		4 Donation 5 Other Specify:	1/28/2009	FOUNTAIN, WV
Balti permit. Departn Imports		21. Signature of Funeral Service Licensee 22. Name and Address of Facility UT	PCHURCH FUET, CUMBER	INERAL HOME, P.A. RLAND, MD 21502
Physician (Modical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial failure. List only one cause on each line.		
/Medical		Immediate Cause (Final disease or condition resulting in death)  a Multiple Injuries  Due to (or as a consequence of):		Death
	-a	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
xecuted n and - transit	cal Ex	d. UNPENDED AMENDED		
'60, ate be ex physiciar he burial	an/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwiting 24 hours after death.  To the Funcared Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	.22	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (Specify)	gnancy	Month Day Year
O. Bo at the de-	, Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to the cause of death?
S, P. I	ted by		1 Yes	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should l	Completed		autops perfor 1 ✓ Yes	med? death?
tal Rec	Be Co	25. Was case referred to medical examiner?   Hospital   Other,   O	eck only one)	
n of Vit ding Physic 1. After this of	2	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 No	28d. Describe	Residence 6 Other:
ion ( rending leath. ror: Af	ation	1 Natural 5 Pending Apr 23, 2009 2343 hrs 1 Yes 2 No		ixed object collision
Division Hospital or Attendi 24 hours after death. Funeral Director: /	Certification	3 Suicide 6 Could not be determined (Specify) Local Street	or Town, S Dans Run Roa	Street and Number or Rural Route Number, City tate) Ashby ad, Fort Ashley, WV
Division  To the Hospital or Attend within 24 hours after death To the Funcral Director: completely filled in by the :		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the caus ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the vithin To the Comple	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
		hy hu, no O.C.M.E.		April 24, 2009
		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		
S Regis	tate tra			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) \_2009 Year April 16, **Physician** 9:25 PM Albert Zagar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel South River Health & Rehab. Center Edgewater If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 6/30/1916 9. Birthplace (State or Foreign Country)
Ohio 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☑ M 2 □ F 713-16-3779 92 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County show if than "natural", or items 23a or 28a-f show 1 AYes 2 □ No Director Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20715 USA 12414 Starlight Ln. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: 1945-46 Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene. m 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Steel Fabricator Prototype Machinery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Lopatic Frank Zagar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 12414 Starlight Lane, Bowie, Maryland 20715 Diana J. Sunday/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 04/18/2009 | Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Celluliti Immediate Cause (Final Sersis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1) 221 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Tue to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal deat

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy Year Month 5 Other (specify) P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: .

completely filled in by the f 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 1 \( \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \( \) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number April 171h MI 10053709 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) lan 216 14300 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryland	•		of Health of Deat		-	giene Reg. No	2000	14990
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)		Fra	hus		Theel		2. Date of Dea Month	ath Da		3. Time of Death  2 4 A M
	Examin Funeral Director	er	376-40-0944	ral Hospi		as <i>t birthday)</i> Yrs.	If Under 1	Columb Year of Unc	ia	8. Date of Biri (Month, Da 10-29-	th	Howai	•
	should be filed within 72 hours after death with the Maryland and Mentyl Hygiene. In a marked other than "natural", or items 23a or 28a-f show umatic event, I'm Madical Exemination at the notified at	Funeral Director	Usual Residence of Decedent  10a, State  10b, County  Maryland  Howard  10e, Street and Number  4846 Avoca Avenu  11. Marital Status	C 2. Was Decedent E		, Town or Lo	10f. Zip C	21043		cify Yes or No	Ur	tizen of What Counited Sta	etes ican Indian,
213-0030	72 hours after of natural", or iter dical Exemina	Completed by Fur	1 □ Never Married 2 ☼ Married 3 □ Widowed 4 □ Divorced  15. Decedent's Educ (Specify only highest grade	Armed Forces? 1 ☐ Yes 2√√ No. If Yes, Give Year or Dates: sation completed)	•	16a, Dece	1 □ Yes 2 2	X∭o Spec	ify:			Black, White, Specify:  Kind of Business/Ir	White
and 2121	2 should be filed within and Mental Hygiene. Is marked other than " aumatic event, II."	Be Compl	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+	-)		alesmar	18. Mo	other's Name	(First, Middle,		Chemical	Company
Marylar	2 should be and Menta Is marked aumatic ev	To B	Carl Oaks Abeel	pe. Print)		1	3	Street and Nui		l Route Numb		or Town, State, Zi	
sanimore, iv	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 Is marked any Injury or other traumatic et once.	1	Irene M. Abeel - W.  20a. Method of Disposition  1 During 2 Cremation 3 R  4 Donation 5 Other (Specify)			ace of Dispendence	osition (Name matory or othe	of er place)	D	ate	20c. L	, Maryla .ocation - City or T kridge, N	
Dail	permit. Departm Importa any inju		21. Signature of Funeral Service Licenson	haven		M	2. Name and MP., In	Address of Fa	cility Gary 250 Was	v L. Ka sh. B1v	ufma d.,	an Funera	al Home at e, MD 21075
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	e. n 1 t i s i consequ a t e	ence of):	(um	or dying, such	as calulac o	п төэрлагот у а	illesi,		Interval Between Onset and Death
68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical Examiner	If any, leading to inneciate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ence of):	ce of):								
)	w requires that the death certific been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗀 Fetal	death 3	☐ Ectopic pre					23d. Date of deli Month	very Day Year
Records, P.	requires that the peen signed by th hould be detache	þ	Part II. Other significant conditions con	where pre	t not resu Union		underlying cau	use given in Pa	art I.	1 🗆	Yes 2	2€No 3□ Pro	the cause of death?  obably 4 Unknown
Vital Red	ian: The law rtificate has b tor, page 2 sl	Be Completed	Hypertencion 25. Was case referred to medical	0 60515				26. P	lace of Death	24a. Was auto perfo	psy ormed? 2₽N	prior to death?	topsy findings available completion of cause of
DIVISION OT V	To the Hospital or Attending Physician: The law within 24 buturs after death.  To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2 s	Certification: To E	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injur (Month, Day) 28e. Place of Injur building, etc	y ; Year)	28b. Time o Injury	М	c. Injury at Work? 1 □ Yes 2	⊇ □No	28d. Describe	how inju	and Number or Ru	cify) ural Route Number,
D	the Hospita thin 24 hours the Funera mpletely fille	Medical C	29a. Certifier (Check only one)  2		examina		nvestigation, i		death occurr		, date ar		to the cause(s)
)	<u> </u>		30. Name and address of person who co	months of de	eath (Item	23a) (Tyne	D	00436				AY 712	

State Registrar William Boyce, MD, 10724 Little Patuxent Pkwy, /200, Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #10a-f Per Type G893 7/02/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Manth 1622 **Physician** 2009 Joseph A. 06 Ariosa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | February 22, 1923 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** New York 1 X M 2 □ F 86 Yrs. 215-12-5793 Director Usual Residence of Decedent 10b. County Monroe Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State FL 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment and the notified at once. 1 ☐ Yes 2 ☑ No Key Largo Baltimor€ **Towson** Director Maryland 10f. Zip Code 10g. Citizen of What Country? ober 23 Lakeside Ave. unit A
Joppa Road #2309 10e. Street and Number 33037 21286 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 **K**]Yes 2 □ No If Yes, Give WW I I Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ 3 X Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical/Electrical CEO 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Dorothy Schofield John Joseph Ariosa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11316 Ridgeway Ave. South, Lutherville, MD Stephen Ariosa / Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Hilltop Service Corp. 05-08-2009 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rucko Townary Funara 2140 me, Inc. 21. Signature of uneral Service Licensee 1050 York Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Subdural hematoma with herniation **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): head in Examiner Closed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINE Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 hypercoaquiopath scundary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 □ No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day, Year) May, 6 2009 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation fall 1200p death. May, 6 1 ☐ Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State)
265 East Japan Rouse Townsen, 1 **S** □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Meryland 21286 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amber Marshall 110 S. Paca ST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 perFh 2891 5/18/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:00 AM 2009 Mildred Birner May Ann/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 3113 Baylriar Road Dundalk If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours  $\frac{218}{212}$  - 28 - 1112 1 □ M 2 T F Beltsville, MD. 75 September 13, 1933 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ence. 10d. Inside City Limits 10a State 10c. City, Town or Location 1 □Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3113 Baybriar Road 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📈 No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8 years College (1-4or 5+) Housewile Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Walter Nicholson Lizzie Nicholson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Debra Birner Daughter-In-Law 3540 McShane Way, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 12 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Unionville. Virginia Oakwood Cemetery 2009 4 □ Donation 5 □ Other (Specify) 21 Signature of Juneral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebro vas anda acciden disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading on its additional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine sician and burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be execute

hours after death.

within 24 hours aft

To the Funeral Di

completely filled in

within 2 To the I

Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

P.O. Box 68760.

Records,

Division of Vital

1 ☐ Yes 2 ☐ No 3 ☐ Probably

24a. Was an autopsy perform Yes 2 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death?

nknown

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rumana Makau Makau Makau

7811 Wise

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State

			ricas	State of Manua					_	•
			1 _ State	State of Maryla					2000	11.003
			Registrar		Ce	rtificate of L	Jeath		ag. No. UU	0 F (D-1)
	Physici	an	Decedent's Name (First, Middle,	10				<ol><li>Date of Deal Month</li></ol>	th Day Yea	3. Time of Death
	/Medio		CIARENCE	Brown				05	04 0	7
	Examir	er	4a. Facility Name (If not institution,	give street and number)	/	21 6	Location of Death	1	4c. County of D	,
			PRINCE	George 1	105P.		ienly n	nd.	PG	
	Funeral		4	109M 200E	s. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, rear)	Birthplace (State or Foreign Country)
	Director		264-20-7196 Usuat Residence of Decedent	18 85	113.			10-14-	1923 F	londin
	and and		10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	f ehc	ō	D.C		11/00	hinda				1 BYes 2 □ No
	28s-	ect	10e. Street and Number		VIII	10f. Zip Code	/ /	T 1	0g. Citizen of What	Country?
	death with the Maryland me 23a or 28a-f ehow Littust be notified at	Funeral Director	121 Fax. 61	118-11	5		002		U.S	
	leath	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.			cify Yes or No-		merican Indian,
	fter d	Ë	1 Never Married 2 Marrie	Armed Forces?		Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto F	Rican, etc.)		/hite, etc.
336	hours after ture!, or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specify:	BIACK
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mentel Hyglene. Item 27 is marked other then "naturel", or iteme 23s or 28s-f show other treumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's		16a. Dece	dent's Usual Occupa	ition		16b. Kind of Busine	ss/Industry
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	be filed tel Hygi d other	Bec	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	(First, Middle, I	Maiden Sumame)	
la	Aente Aente rked tic e	To	Willie	Brown			Anniesli	ZA	GARVIN	
Maryland	sho and h is ma		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Maili	ng Address (Street a	and Number or Rura	Route Number	, City or Town, Stat	e, Zip Code)
	and alth		Ethel M.	Brown	121	Charlelin	ST. N.E	Wes	hemotor ,	)·( 20002
ore.			20a. Method of Disposition		Place of Disponentery, cre	osition (Name of matory or other place	p)   Da	ate	20c. Location - City	or Town, State
Ĕ	Pag ient nt; I		1 🗷 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		GIENI		05-1	3-09	Washin	fow, O.C
Baltimore,	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service L	icensee		2. Name and Addres	s of Facility The	14005	e 06 W	HIAMS
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-	Physician	13	Immediate Cause (Final	At		work C				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse		W-0112 -	250 6 100	as wil	ar sign	a openio
н	Examiner									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
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1760,	nysicien nysicien ne burial	cai	24	d						
68	death certificate   ettending physi	Jed	IF FEMALE:							
Вох	th ce tendii r use	an/	23b. Was decedent pregnant	23c. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe		□Ectopic pregnancy			23d. Date of	
	dea he et ed fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of 9 Unknown		Other (specify)			Month	Day Year
P.O.	at the by th	جُ	9 Unknown							
	es th igned	<u>م</u>	Part II. Other significant condition	h c to death but not re	sulting in the o	inderlying cause give	en in Part I.			e to the cause of death?
ord	The law requires that the death ste has been signed by the ette page 2 should be detached for	Completed by Physiclan/Medl	011.011.0	11/20100	> N	4 1717	- Char	1 L Y	es 2□No 3⊡	Probably 4 □Unknown
Ö	as b	g	ATRIAL FIBE	The Con	Sestin	eneary	Gallone	24a. Was a autops	n 24b. Were	autopsy findings available to completion of cause of
<u> </u>	The date h	5	BladderCa	ncer		C		perform 1 ☐ Yes	med2 deati 2 ☑ No 1 ☐ `	17
ita	cian: ertific rctor,	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only on	10)	
of Vital Records,	hysic his or I dire	ှု	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie		4   Nuising Hon	ne 5 ☐ Reside	ence 6 □Other (5	Specify)
Ē	of P	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Work	at 2	8d. Describe h	ow injury occurred	
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Ξ	or At Iter d Irect	틭	4 Homicide determin		home, farm, st cify)	reet, factory, office	2	8f. Location (Si City or Town		Rural Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has sompletely filled in by the funeral director, page 2	Medical	(Check only 2 Medical E	Physician: To the best of my kr xaminer: On the basis of examin	nowledge, deal nation and/or in	th occurred at the time evestigation, in my op	e, date and place, a pinion, death occurre	ind due to the c ed at the time, d	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.	· · · · · · · · · · · · · · · · · · ·	29c. License	number		9d. Date signed (M	onth Day Year)
	F ₹ O		250. Signature amounte di certifier	1. Online	h	1 Don License	1800		Mc.	7 000
			June	muit	- m	x JU	1030		744 6	2001
			30. Name and address of person w	ho completed cause of death (Ite	om 23a) (Type	Print)	Rd Hu	attou	HE MD	20781
	- C4-	<b>†</b>	31. Date filed (Month, Day, Year)	3% Registrar's Sign	name A	ake	1			
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DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Mai	,	Certificate of		R	leg. No	19	14994
	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day	Year	3. Time of Death 16:30 PM
	/Medic	al	Dorotea  4a. Facility Name (If not institution, give	Bryce		4b. City. Town, o	or Location of Death	1 -	28 , 20 4c. County		10.301
. 5	Examin	er	Holy Cross Hos				r Sprin		Mont	gome	ery
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birth	day) If Under 1 Year Months Days		8. Date of Birth	Year) 1,193	Coun	ace (State or Foreign try) 1ama
	pu ,		Usual Residence of Decedent  10a. State 10b. County	1.	10c. City, Town	or Location				10	Od. Inside City Limits
	e Maryla 8a-f shov tifled at	ctor	MD Montgo			Silver Sp	ring				1 XYes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, i'm, i'm, die al. Framiner must be notified at once.	Funeral Director	10e. Street and Number 601 East Randol	ph Road	<b>#</b> 323	10f. Zip Code 20	910		10g. Citizen of V USA		try?
(0	fter deat r items :	Funer	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ev Armed Forces? 1 ∐Yes 2 [XNo		13. Was Decedent of I		pecify Yes or No- o Rican, etc.)		ce - Americ ck, White, e	tc.
000	ours a	d by	3 ☐ Widowed 4 【X*Divorced	If Yes, Give Year or Dates:		1⊠Yes 2□No	Pana	amanian			ack
Maryland 21215-0036	ain 72 h e. an "natu Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(	Decedent's Usual Occu Give kind of work done life. DO NOT use retire	pation during most of wor ed)	king	16b. Kind of B		
2	ed with	Com		5+	Bi	lingual C	1			ivate	9
and	be file	Be	17. Father's Name (First, Middle, Last)	i			18. Mother's Nar	ne <i>(First, Middl</i> e, Bever		n <i>e)</i>	
<u>Z</u>	should nd Mei marke imatic	오	Oscar Lowe  19a, Informant's Name/Relationship (	Type, Print)	196	Mailing Address (Stree				, State, Zip	Code)
, ⊠	alth ar alth ar 27 is er trau		Rene Bryce-Lapo	· .	16   Wa	Mailing Address (Stree 73 Columb shington,	DC 20	009 #50	) <del>9</del>		
Baltimore,	ges 1 a t of He If item or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of 0	Disposition (Name of crematory or other pla T Heaven	ice)	Date	20c. Location	- City or To	wn, State
<u>H</u>	it. Pag rtmen rtant: njury		4 □ Donation 5 □ Other (Specify	(y)	Cemet	2 Y W	UNLAV	7,2009	Silv	er S Fun	pring.MD eral Home
Ba	permi Depar Impor any Ir		21. Signature of Funeral Service Licer	ISEE (		3821 14t	h Stree	t,NW,Wa	shing	ton,	OC 20011
			23a, Part 1. Enfer the disease, or com shock, or heart failure. List only	plications that caused the	he death. Do no	ot enter the mode of dy	ing, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
-	Physician		Immediate Cau (Final disease or con ition resulting in death)	a. Intrace:	rebral	Hemorrha	ge				Onset and Death
7	/Medical Examiner		resulting in deality		consequence of		Homory	hago			
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on o	ding h. After fune	tion:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day,	Year) 28b. Ti	jury   Wo	ury at ork? ⊒Yes 2 ∐No	28d. Describe I	now injury occu	rrea	
Division of Vital Records,	Atten r deal ector: by the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e Place of Injur	ry - At home, far (Specify)	m, street, factory, office		28f. Location (8 City or Tov	Street and Num wn, State)	ber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical Co	29a. Certifier 1 Certifying Pl (Check only one)	hysiclan: To the best of miner: On the basis of and manner stat	examination and	death occurred at the	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and r date and place	nanner as s , and due t	stated. the cause(s)
	To the vithin :	Mec	29b. Signature and title of certifier	and manner state		29c. Licer	nse number		29d. Date sign	ed (Month,	Day, Year)
						D6:	5953		Apri	1 29	, 2009
7	0 V		30. Name and address of person who				- A C-1-	ZON Com	ing M	נ מו	0910
		te-	Adaku Onukogu, I	MD 1500 82. Registrar		Glen Ro	ad, SIIV	er spr	Ing, M	עו ע	0910
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5/8/09 Day **Physician** 3 AM LOVIE MAE BAIRD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PASADENA A.A. (HOME) 804 RIVERSIDE DR. N.E. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Months Days Hours 1 □ M 2 1 F TENNESSEE 410 05 5241 92 4/16/17 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be realised at 1 ☐ Yes 2 No Director PASADENA MD. A.A.CO. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 804 RIVERSIDE DR. N.E. 21122 Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. If Yes, Give Year or Dates: Specify: BLACK Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be file of Health and Mental Hy fitem 27 Is marked oth Be ARTHUR THOMAS ASSIE LEE SMITH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 RIVERSIDE DR.N.E. PASADENA MD. 21122 HELEN POLK permit. Pages 1 a
Department of Her
Important: If Item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place ORGAN CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/15/09 CROSS PLAIN TN. 4 Donation 5 Dother (Specify) 21. Signature de eral Service Licensee Name and Address of Facility
ESTEP BROS. FU
1300 EUTAW PL. FUNERAL HOME P.A. BALTIMORE. Approximate Interval Between Onset and Death Part Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of) ing physician a as the burial P.O. Box 68760, The law requires that the death certificate be Physician/Medical this certificate has been signed by the attending particities as all director, page 2 should be detached for use as IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform**ę**c 2 No 1 ☐Yes 2 No 1 TYes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death
Natural
2 Accident 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

Date filed (Month, Day, State

29b. Signature and title of certifier

eted cause of death (Item 23a) (Type, Print

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Carrie Physician Month Ye ar 11:30 2009 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memoria Hospita Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days 231-07-8330 1 ☐ M 2 🕏 90 Iraina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 1 Yes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 45, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after deal and Mental Hygiene. is marked other than "natural", or items : 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☑No ģ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Geographics of work done during most of working life, DO NOT use retired)

Nurses 1557 Start Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be Caroline Holl ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any Injury or other traur Way granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other p City or Town, State 20a. Method of Disposition Date 20c Location -Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryler 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune at ervice Licens iara 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 7 days neumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trai Due to (or as a consequence of): attending physician Physician/Medical the for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 ZNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide

execute Box 68760 The law requires that the death certificate be P.O. I Division of Vital Records,

Baltimore, Maryland 21215-0036

Registrar

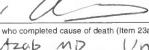
31. Date filed (Month, Day, Year) State

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Medical



and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) May. 6,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond

Hospital, MD MD nion Memorial

32. Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg No 2 0 0 9										19 11	997	
			Registrar  1. Decedent's Name (First, Middle,	Last)		Reg. No. 2 2. Date of Death 3. Time of Death						
Н	Physici /Medi		Roberta E.	Boyd						Year	lo AM	
*	Examir		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Deat	05	4c. County o	007		
· And			University of Maryland medical lenter Baltimore NI									
	Funeral	Director	5. Social Security Number	S. Sex	e (In yrs. last birthday,		If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	9. Birthplace (State	or Foreign	
	Director		Usual Residence of Decedent	10 M 2001	59 Yrs.		Jan. 24	1950				
	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Exympter must be notified at		10a. State 10b. County	1.4	10c. City, Town or Lo	ocation 7	11.			10d. Inside Q	Lity Limits	
			Maryland 1	VIA		Bal	TIMER			1 TYes 2		
			10e. Street and Number	11-11		10f. Zip Code		1	0g. Citizen of WI	tizen of What Country?		
	23a	ral	5301 Carrai	ge Hill		2	1229		U	USA		
	tems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origin? (S a, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, , White, etc.		
36	s afte	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	VO !	1 ☐ Yes 2 ☑ No		, , ,	Specify:			
21215-0036	tural	To Be Completed t	15. Decedent's	Year or Dates:	16a Dece	dent's Usual Occupa	ation		16b. Kind of Bus			
215	nin 72 e in "na		(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Give	kind of work done do DO NOT use retired)	uring most of wor	king	trans			
21,	d with		Elementary Secondary (0-12)	College (1-4or 5	)+)	Stewa	rd		11 2000			
nd	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, Ill ODGE.		17. Father's Name (First, Middle, La	ist)			18. Mother's Nan	ne (First, Middle, M	faiden Surname	)		
yla			Kobert Le	rand			Marth	a alle	<i>Y</i>			
Maryland			19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street a	nd Number or Ru	iral Route Numbe	City or Town, S	State, Zip Code)	21228	
			20a. Method of Disposition	son augu	SOL Disease Disease	- Mervin	1 Arrei 1	TPT /T	Catons	Ville, Mar	y and	
Baltimore,			1 ☐ Burial 2 ☐ cremation 3	☐ Removal from State	cemetery, cre	osition (Name of matory or other place	) de	Date	20c. Location - C	City or Town, State	1. 1.	
를			4 □ Donation 5 □ Other (Special Service Lie		METTO	2. Name and Address	of English	109	LETURSY	le ruy	and	
Ba			Devin	Harrin	1 2	572 Fred	la cick	Jer Fur	eray m	ME THE	1129	
			23a. Part1. Enter the disease, or co	emplications that caused	the death. Do not en	ter the mode of dying	, such as cardiac	or respiratory arre	est.	Approxima:	te	
isp	Physician		Immediate Cause (Final	y one cause on each line.  AID:								
	/Medical		disease or condition resulting in death)	a	a. Due to (or as a consequence of):							
	Examiner		On any stire that the stire	Liver	A							
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as								
/	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с								
8760,		E E	recenting in death) East	Due to (or as a	a consequence of):							
687	ficate phys s the	dical		d				-				
Box (	eath certific attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				004 0-4-	004 Data - 6 dalla		
m	death e atte	icial	in the past 12 months?			23d. Date of delivery  Month Day Year						
P.0.	Ine law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	9 Unknown									
Š			Part II. Other significant conditions	contributing to death but	23e. Did tob	bacco use contribute to the cause of		death?				
p	w require s been si should t	ed			1 ☐ Ye	]Yes 2□No 3□ Probably 4戊\Unkno						
မင	e faw n has be e 2 shi	Completed		24a. Was an		24b. Were autopsy findings available						
<u> </u>	The page	8						autopsy perform 1 X Yes 2	ed? de	or to completion of c ath? ⊒Yes 2⊠No	ause of	
/ita	Physician: r this certificanal director, p	Be C	25. Was case referred to medical examiner?					th (Check only one				
of	Physical this call dire	၉	1  Yes 2 No		nt 2 ER/Outpatier		4 LI Nursing H	ome 5 Reside	nce 6 Other	(Specify)		
ב	io the hospital or Attending Physician: The living 124 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	<u>ö</u>	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	(y 28b. Time of Injury	Work?		28d. Describe hor	d. Describe how injury occurred			
S		icat	2 Accident investigat 3 Suicide 6 Could not	be 200 Place of Inju					001 1			
Division of Vital Records,		Certification:	4 ☐ Homicide determine	building, etc.	. (Specify)	set, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
1	he Hc in 24 he Fu pletel	Medical	(Check only 2 ☐ Medical Ex	aminer: On the basis of and manner stat	examination and/or in	vestigation, in my opi	inion, death occu	rred at the time, da	te and place, an	d due to the cause(s	3)	
	To the within 2 To the comple		29b. Signature and title of certifier	(Resid		29c. License	number	29	d. Date signed (	Month, Day, Year)		
				- William	Nghiem, ma	185153	79223	1	nay o	4 , 2000	1	
			30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type,	Print)			0			
			31. Date filed (Month, Day, Year)	g hem M	r's Signature	25 GREEN	STIBA	1Timore	m)	21201		
	Stat Registra	~	MAY 112	009 Dun	rath (Item 23a) (Type,	and						
			= = 6	/	- 17	1975						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 РМ 9:15 <u>Billie Lee Brand</u> May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8643 Tower Bridge Way Lutherville If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 500-40-0936 Days 1 □ M 2 😿 F Montana February 8, 1941 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Lutherville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21093 U.S.A. 8643 Tower Bridge Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles McCormick Catherine Oblev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 260 Stanmore Road, Baltimore, Maryland 21212 Bethany Brand / Daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Hilltop Service Corp. 05-09-2009 Towson, Maryland 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home Inc. 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocardial intarction Acute hour disease or condition resulting in death) Due to (or as a consequence of): 1060660 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death' 2 🗆 No 1 □ Yes 2 40 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊡No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra attending physician for use as the buria After this certificate has been signed by funeral director, page 2 should be detact Records, of Vital Division s after death I Director: filled in by the

24 hours a

within 2.

Examiner Physician/Medical ò Be

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

Completed by

Be

2

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after death with the and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a.

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur

Physician

/Medical

Examiner

Maryland 21215-0036

Baltimore,

Completed Certification: To

4 Homicide 29a. Certifier (Check only

29b. Signature and title of certifier

uzanne

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.

6565 North Charles Street 32. Registrar's Signature

camese

1 🛮 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO056156

29d. Date signed (Month, Day, Year)

21204

Mary lane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per Fh 8892 6/3/09 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Carol Burton Butler AM 2009 8:07 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1604 Orlando Road Parkville Baltimore 5. Social Security Nuglto If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 5, 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min <sup>Year)</sup> 1945 1 □ M 2 😿 F 63 Director 215-44-<del>1313</del> Maryland Usual Residence of Decedent the Maryland 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Worldal Exantinal russ be neithed at 1 ☐ Yes 2 X No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 1604 Orlando Road Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify ģ Specify: 3 ☐ Widowed 4 🛛 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Substance Abuse Elementary/Secondary (0-12) College (1-4or 5+) 5+ Executive Director Treatment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Carroll Wernig Edna Burton ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any injury or other traus Jamin Butler / Son 6677 Loch Hill Road, Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State HiThtop Service Corp. 05-09-2009 Towson, Maryland 4 Donation 5 ☐ Other (Specify) uneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YOUY ONe 1/norvan disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) ed by the detached i 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □Yes 2 ☑ No certificate 1 ☐Yes 2 ØNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 24 hours after death. e Funeral Director; After thi letely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Belvelere A Lober, Kennel RUB 2435 31. Date filed (Month, Day, Year) 32 Aegistrar's Signatur State 2009 Registrar

				for State Registrar	State of N	/larylan	•	rtmen <i>tificate</i>		ealth and I Death	Mental Hy	giene Reg. No2	009	15000	
		Physici /Medi		1. Decedent's Name (First, Middle, Last)  John J. Chovan						2. Date of De Month	Day	Year <b>2004</b>	3. Time of Death (0:38 A-M		
4	and the same	Examir		4a. Facility Name (If not institution, give street and number) Sinai Hospital of Rultimore				4b. City, Town, or Location of Death  Baltimore			4c. County of Death N/A				
	21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 65 5 and 1 injury or other traumatic event, Ite Medical Eventher: ust be notified at 2000.		5. Social Security Number 6. S		7. Age (In yrs. last birthday)		If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb.	9. Birthplace (State 22, 1967 Korea		place (State or Foreign ntry) (Orea	
			ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A									10d. Inside City Limits		
Ş			Dire	Maryland N/A Baltimore 10e. Street and Number 2603 N. Hilton Street 21216								10g. Cîtize	n of What Coul	ntry?	
Chovan			Completed by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ➢ No If Yes, Give Year or Dates:		1	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 No Specify:			pecify Yes or No o Rican, etc.)			ce - American Indian, ck, White, etc.	
John			ompleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12th grade	ducation ade completed) College (1-4o	r 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Lot Attendant				king	Parking Garage			
,	land		To Be C	17. Father's Name (First, Middle, Last, Unk •	)	18. Mother's Name (First, N Un!c •					ne (First, Middle	fiddle, Maiden Surname)			
	, Mary			19a. Informant's Name/Relationship ( Eric Bess/ frie	-   0.00			ng Address (Street and Number or Rural F N. Hilton St. B			ral Route Numb Balti	Route Number, City or Town, State, Zip Code) Baltimore, Md 21216			
	Baltimore, Maryland		1	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cometery, crematory or other place)  Cometery, crematory or other place)  Cometery, 7/09  Date  20c. Location - City or Town, State  Baltimore, Marylar									_		
				21. Signature of Fundal Service 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, 21215											
4		Physician /Medical Examiner		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  Due to (or as a consequence of):											
	ecords, P.O. Box 68760,	ite be executed iysician and ie burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c										
			ca	· ·	<b>▲</b> d.										
		To the Hospital or Attending Physiclan: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year				
		quires that: n signed by ald be detad	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown					
		<b>Physiclan:</b> The law rec rthis certificate has bee ral director, page 2 shou	Completed							24a. Was an autopsy performed? 1 \[ \text{Yes} \ 2 \] No \[ 1 \] Yes \[ 2 \] No			ompletion of cause of		
		/siclar s certif	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3					26. Place of Death (Check only one)  3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)					ifu)	
	on of	Attending Physic death. ector: After this by the funeral of	ition: T	27. Manny of Death  1	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury						28d. Describe how injury occurred				
	Divisi	al or Atter s after dea tl Director ed in by the	Certification: To	3 Suicide 6 Could not b						28f. Location (Street and Number or Rural Route Number, City or Town, State)			ral Route Number,		
		e Hospital 124 hours a e Funeral I	Medical C		nysician: To the be miner: On the basis and manner	of examina									
	_	To the within 2	Me	29b. Signature and title of certifier  29c. License number					29d. Date signed (Month, Day, Year)						

RES-000 4/29/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Auchim Bhuhu M.D. Sinai H

31. Date filed (Month, Day, Year)

32. Registrar's Signature Sinai Hospital of Baltimore

State Registrar